Electronically Delivered

July 10, 2023

Licensee
Norbella Senior Living Prior Lake
4285 Fountain Hill Drive Northeast
Prior Lake, MN 55372

RE: Project Number(s) SL37315015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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 MDH 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. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37315	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA SENIOR LIVING PRIOR L	4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37315015 On June 12, 2023, through June 14, 2023, 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 29 active residents; all receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1	0 510		

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 infection control standards were followed for disinfecting reusable equipment for one of one unlicensed personnel (ULP-D) during personal cares for R3. In addition, the licensee failed to ensure infection control standards were followed for three of three ULPs (ULP-M, ULP-O, ULP-P) during dining. This had the potential to affect all resident receiving service under the assisted living with dementia care license.

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

The findings include:

DISINFECTING REUSABLE EQUIPMENT

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0 510	Continued From page 2 R1's diagnoses included diabetes and dementia. R1's service plan dated June 12, 2023, indicated R1 received the following services: vital signs on the 12th day of the month, medication management, dressing, grooming, transferring, toileting, and housekeeping. On June 12, 2023, at 4:31 p.m., unlicensed personnel (ULP)-H retrieved the thermometer, blood pressure machine, and oxygen saturation monitor from a drawer in the medication cart. ULP-H walked over to R1, who was sitting at a table on the unsecure unit with two other residents, and performed temperature, pulse, blood pressure, and oxygen saturation monitoring. After performing R1 vital signs, ULP-H returned the thermometer, blood pressure machine, and oxygen saturation monitor back to the drawer in the medication cart without disinfecting the equipment. ULP-H stated she did not disinfect the equipment after performing R1's vital signs because she is the only resident who had vitals performed today. ULP-H stated she cleans the equipment at the end of her shift. HAND HYGIENE/GLOVES During a dining observation on the secured unit June 12, 2023, from 4:53 p.m. to 5:26 p.m., the surveyor observed the following: -at 5:01 p.m., ULP-P, wearing gloves, went into the kitchen and brought out a cart with bowls of soup and started serving residents' soup. ULP-O and ULP-M were escorting residents to the dining room both wearing gloves and not completing hand hygiene or changing gloves in between residents. -at 5:04 p.m., wearing the same pair of gloves and without performing hand hygiene, ULP-O	0 510		

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0 510	Continued From page 3	0 510		

started pouring and delivering residents coffee.
-at 5:11 p.m., ULP-M exited R9's room wearing gloves and escorted R9 to the dining room. ULP-O was wearing gloves and providing feeding assistance to R3. ULP-O stopped feeding R3, got up from the table and assisted R9 with putting on a shirt proctor, then ULP-O proceeded to assist R3 with her soup without changing gloves or performing hand hygiene. After ULP-O assisted feeding R3, ULP-O assisted R10 with her soup wearing the same pair of gloves and without performing hand hygiene.
-at 5:16 p.m., ULP-P exited R14 's room wearing gloves, escorted R14 to the dining table and without changing gloves or performing hand hygiene, ULP-P entered the kitchen, obtained the meal cart, and started serving residents their meals.
-at 5:19 p.m., ULP-M cleared R10's dishes from the table and without changing gloves or performing hand hygiene, ULP-M cut up R12, R11 and R10's sloppy joes. ULP-M removed gloves, washed hands, and put a new pair of gloves on and started to head back to the dining room.

On June 12, 2023, at 5:26 p.m., ULP-M stated staff usually wore gloves in the dining area when assisting with feeding residents or handling food. ULP-M stated she did not realize she only changed her gloves and washed her hands one time during the dining experience. ULP-M stated she should have either changed her gloves or performed hand hygiene in between residents and handling resident's food.

On June 12, 2023, at 5:55 p.m., clinical nurse supervisor (CNS)-B stated reusable equipment should be cleaned after each use. CNS-B stated staff were not instructed to wear gloves during

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0 510	Continued From page 4 dining and if staff chose to wear gloves, staff were expected to change their gloves in between residents and/or perform hand hygiene. The licensee's undated Disinfecting Reusable Equipment and Environmental Surfaces policy, indicated after using reusable equipment, the equipment must be cleaned and returned to the place that it is stored. The licensee's Hand Hygiene policy darted July 23, 2021, indicated hand washing should be performed whenever direct physical contact with a resident took place, after removing gloves and the use of gloves did not replace hand washing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	0 630		

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0 630	Continued From page 5 Based on observation, interview and record review, the licensee failed to ensure individual abuse prevention plans were updated for two of four residents (R2, R3) with changes in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included transient ischemic attack (TIA), congestive heart failure, hypothyroidism, and adjustment disorder with depressed mood. On June 13, 2023, at 8:50 a.m., regional director of operations (RDO)-D provided the surveyor a copy of R3's Individual Abuse Prevention Plan (IAPP) dated June 12, 2023. At 11:14 a.m., RDO-D stated after the surveyor requested R2's IAPP on June 12, 2023, RDO-D noticed R2 and R3's IAPPs were over six months old and had not been updated to reflect R2's or R3's current status. RDO-D had clinical nurse supervisor (CNS)-B complete updated IAPP's for R2 and R3. The surveyor requested a copy of R2 and R3's previous IAPP. RDO-D provided R2 and R3's IAPP dated June 19, 2022, and July 29, 2022. R2's IAPP dated June 19, 2022, indicated R2 behaviors posed no risk to self, no verbal abuse, no threatening behavior and no inappropriate	0 630		

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0 630	Continued From page 6 sexual behavior. R2's Master Assessment dated March 22, 2023, indicated R2 had depression, a history of being combative with cares, verbal aggression toward staff, and resistive with cares. R2's Progress Notes indicated the following: -March 26, 2023, at 8:52 a.m., R2 started combative behavior. R2 tried to get out of bed with his legs almost on the floor and do not want to go back to bed when staff approached him. R2 threatened to hit and punch staff and staff to leave his apartment. -March 27, 2023, 11:59 a.m., R2 is often non-compliant/resistive. -May 2, 2023, 6:38 a.m., R2 was trying to get out of bed hallucination and hitting staff while we were trying to reposition R2 and change R2's brief. -May 4, 2023, at 5:21 a.m., R2 is hallucinating, trying to get out of bed. Staff are having difficulty approaching R2 as he is becoming agitated and kicking. R2 refusing to take any medication. On June 13, 2023, at 6:45 a.m., unlicensed personnel (ULP)-I stated R2 received the following cares: repositioning, change adult brief, assistance with oral care and grooming, and meal delivery. ULP-I stated R2 spends most of the day in bed. He had not fallen lately. On June 13, 2023, at 7:35 a.m., R2 was observed to make sexually inappropriate comments to ULP-I and ULP-J while providing morning cares. ULP-I stated R2 often make sexually inappropriate comments. ULP-I stated ignoring the sexually inappropriate comments often works the best.	0 630		

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0 630	Continued From page 7 R2's IAPP dated June 12, 2023, (completed after IAPP was requested) indicated R2 exhibited behaviors posing a risk to self, demonstrated verbal abuse or threatening behaviors, and demonstrated physical violence or potential harm, such as hitting, kicking, pushing, biting or grabbing. Interventions include staff to reproach as needed during periods of noncompliance, reassure resident during resistiveness/hallucinations, utilize PRN's (as necessary medications, and follow up with RN (registered nurse). R3 R3's diagnoses included dementia. The licensee's Resident Incident/Accident report dated January 11, 2023, through June 4, 2023, indicated R3 had 16 reported falls. R3's IAPP dated July 29, 2022, indicated R3 was orientated to time, place, and person, was able to ambulate safely, and had no behaviors posing a risk to self. R3's Master Assessment dated February 23, 2023, indicated R3 had a change of condition/services assessment due to frequent falls, has dementia, wandered, and requires assistance with transferring. R3's Master Assessment dated June 1, 2023, indicated R3 had a change of condition/services assessment due to requiring a mechanical lift for transferring. R3's IAPP dated June 12, 2023, (completed after IAPP was requested) indicated R3 had periods of disorientation, required two-person assistance with transfers, dressing, grooming and toileting,	0 630		

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0 630	Continued From page 8 and behaviors included frequent self-transfers leading to falls. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy reviewed October 27, 2021, indicated an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 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 9 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 interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 Assisted Living Disaster and Emergency Plan revised October 25, 2022, lacked the development of a risk assessment to describe potential hazards that would be likely to impact the licensee geographical region, community, facility and patient population. On June 14, 2023, at 4:01 p.m., licensed assisted living director (LALD)-A stated she was responsible for developing and maintaining the licensee's emergency plan. LALD-A stated after reviewing the Assisted Living Disaster and	0 680		

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0 680	Continued From page 10 Emergency Plan binder she was unable to find a facility risk assessment in the plan or an electronic form. LALD-A stated she thought she completed a facility risk assessment. LALD-A stated she was unable to find documentation the licensee had participated in tabletop, full-scale community or facility wide or exercises. The licensee's Assisted Living Disaster and Emergency Plan dated October 25, 2022, indicated implementation of the Emergency Response Plan was the responsibility of the executive director, LALD and the LALD would work with the Incident Management Team (IMT) to respond to an emergency No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730		

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	37315	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORBELLA SENIOR LIVING PRIOR L	4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372

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0 730	Continued From page 11 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure services that have been provided as identified in the service plan were documented for three of four residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 730		

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0 730	Continued From page 12 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's diagnosis included heart failure. R2's service plan dated February 1, 2023, indicated received the following services: assistance with toileting (12:00 a.m., 4:00 a.m., 6:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 4:00 p.m., 9:00 p.m.), repositioning (2:00 a.m., 6:00 a.m., 10:00 a.m., 10:00 p.m.), dressing (twice a day), grooming (twice a day), oral care (twice a day) safety checks (10:00 p.m.), meal delivery (three times a day), and housekeeping (weekly). R2's Service Checkoff List for May 2023 indicated the following: -toileting (12:00 a.m.) were not documented three (3) out of 31 opportunities; -toileting (2:00 a.m.) was not documented two (2) out of 31 opportunities; -toileting (4:00 a.m.) were not documented two (2) out of 41 opportunities; -toileting (9:00 a.m.) were not documented one (1) out of 31 opportunities; -toileting (11:00 a.m.) were not documented one (1) out of 31 opportunities; -toileting (1:00 p.m.) were not documented one (1) out of 31 opportunities; -toileting (4:00 p.m.) were not documented three (3) out of 31 opportunities; -toileting (9:00 p.m.) were not documented three	0 730		

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0 730	Continued From page 13 (3) out of 31 opportunities; -repositioning (6:00 a.m.) were not documented one (1) out of 32 opportunities; -repositioning (2:00 p.m.) were not documented five (5) out of 31 opportunities; -repositioning (6:00 p.m.) were not documented three (3) out of 31 opportunities; -repositioning (10:00 p.m.) were not documented two (2) out of 31 opportunities; -dressing (6:00 a.m.) were not documented one (1) out of 31 opportunities; -dressing (8:00 p.m.) were not documented four (4) out of 31 opportunities; -grooming (6:00 a.m.) were not documented one (1) out of 31 opportunities; -grooming (8:00 p.m.) were not documented four (4) out of 31 opportunities; -oral care (6:00 a.m.) were not documented one (1) out of 31 opportunities; -oral care (8:00 p.m.) were not documented four (4) out of 31 opportunities; -safety checks (10:00 p.m.) were not documented two (2) out of 31 opportunities; -meal delivery (8:00 a.m.) were not documented one (1) out of 31 opportunities; -meal delivery (12:00 p.m.) were not documented one (1) out of 31 opportunities; -meal delivery (5:00 p.m.) were not documented three (3) out of 31 opportunities; and -housekeeping were not documented four (4) out of four (4) opportunities. R3 R3's diagnoses included dementia, aphasia, weakness, and osteoarthritis. R3's service plan dated March 15, 2023, indicated R3 received weekly housekeeping on Wednesdays.	0 730		

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0 730	Continued From page 14 R3's Service Checkoff List for May 2023, indicated the following: -housekeeping was not documented five (5) out of five (5) opportunities. R4 R4 was admitted on May 23, 2023. R4's diagnoses included congestive heart failure, spinal stenosis (narrowing of the spine), and pain left lower leg. R4's service plan dated June 7, 2023, indicated R4 received weekly housekeeping on Wednesdays. R4's Service Checkoff List for May 2023, and June 2023, indicated the following: housekeeping was not documented two (2) out of two (2) opportunities in May 2023, and one (1) out of one (1) opportunity in June 2023. On June 13, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated R2, R3 and R4's services were not documented as indicated above. The licensee's Resident Record policy dated July 28, 2021, indicated the resident's record would include documentation that services have been provided as identified in the service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01060 SS=E	144G.52 Subd. 9 Emergency relocation	01060		

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01060	Continued From page 15 (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 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	01060		

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01060	Continued From page 16 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 for an emergency relocation to the resident, legal representative, or designated representative. Further, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for two of two resident (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's service plan dated June 12, 2023, indicated R1 received assistance with medication management, blood glucose monitoring, dressing, grooming, bathing, toileting, transferring, catheter care, and housekeeping. R1's Progress Notes included the following: -January 19, 2023, R1 was transported to the emergency room for evaluation; -February 13, 2023, R1 was transferred to a TCU (transitional care unit); and -June 9, 2023, R1 returned to the facility.	01060		

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01060	Continued From page 17 R2 R2's service plan dated February 1, 2023, indicated R2 received assistance with medication management, bathing, grooming, transferring, toileting, and housekeeping. R2's Progress Notes included the following: -March 13, 2023, R2 was transported to the emergency room for evaluation; -March 14, 2023, R2 was transferred to another medical facility; and -March 22, 2023, R2 returned to the facility. R1 and R2's records lacked documentation R1 and R2's designated representative received an emergency relocation notice with all required content and further R1 and R2's records lacked documentation the OOLTC was notified of R1 and R2's relocation of an overstay of four (4) days. On June 13, 2023, at 10:42 a.m., licensed assisted living director (LALD)-A stated the clinical nurse supervisor (CNS) was not aware of the need to give the emergency relocation notice to residents and not aware of the need to notify the OOLTC if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01170 SS=F	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative	01170		

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01170	Continued From page 18 of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to: (1) conditions that render the resident's room or private living unit uninhabitable; (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a 30-day calendar day advance written notice to the resident and/or the resident's legal/designated representative, prior to initiating the transfer for two of two residents (R1, R3). 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	01170		

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01170	Continued From page 19 a large portion or all of the residents). The findings include: On June 12, 2023, at 12:45 p.m., during the entrance conference, licensed assisted living director (LALD)-A provided a copy of the current resident roster. The current resident roster June 12, 2023, indicated R1 resided in room 112. At 2:15 p.m. LALD-A stated R1 was hospitalized, transferred to a TCU (transitional care unit), and returned to the facility on June 9, 2023. LALD-A stated R1 was transferred into room 124 when R1 returned to the facility. R1 On June 12, 2023, at 5:00 p.m., the surveyor observed R1 in room 124. On June 13, 2023, at 3:05 p.m., LALD-A stated R1 was moved so she would be closer to the nurse's station. LALD-A stated R1 was a "heavier" resident, and it would be a long distance for the staff to push R1 in her wheelchair with her oxygen to the dining room and activity area on the assisted living unit. LALD-A also stated the move from room 112 to 124 was initiated by the facility and discussed with R1's son. LALD-A provided the surveyor a copy of an email sent to R1's son. On May 23, 2023, at 9:26 a.m., clinical nurse supervisor (CNS)-B sent an email to R1's son. The email indicated I wanted to see if you would be open to moving your mom to an apartment closer to our current "hoyer lift". It is also closer to the aide station on "AL" [unsecure unit]. I think it would benefit your mom's care. Let me know if you would be open to doing this- it would be room 124.	01170		

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01170	Continued From page 20 On May 23, 2023, at 11:59 a.m., R1's son responding in an email indicating "Absolutely". I will work on getting things boxed up. Do I need to sign different documents? I could sign them next Tuesday? R3 R3's progress notes dated February 22, 2023, indicated the provider spoke with R3's Power of Attorney (POA) and discussed it was time for R3 to transition to the secured unit. R3's POA was not in agreement at that time and the note indicated R3's POA believed it would disrupt R3's routine and would be more "detrimental" for R3 to move. R3's progress notes dated March 8, 2023, indicated R3 would be transitioning to the secured unit on March 15, 2023, due to an increase in care needs. R3's progress notes dated March 15, 2023, indicated R3 transitioned to the secured unit, services were updated, and a service addendum to be signed. On March 12, 2023, at 7:07 p.m., an email was sent from R3's POA inquiring if R3's transition to the secured unit was still planned for March 15, 2023, and inquired about the services R3 would receive on the secured unit. CNS-B responded and discussed R3's upcoming transition to the secured unit of the change in care level costs. The facility lacked documentation showing a 30-day written notification was provided to residents and the residents' legal and designated representative as required that contained the following: - (a) facility must provide at least 30 calendar	01170		

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01170	Continued From page 21 days advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer; - the effective date of the proposed transfer; - the proposed transfer location; - a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; - the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and - contact information for OOLTC. June 13, 2023, at 3:05 p.m., LALD-A stated a 30-day written notice was not provided to resident R1 and R3 or the resident's legal designated representative that contained the required information as indicated above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01170		
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);	01470		

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01470	Continued From page 22 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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	01470		

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01470	Continued From page 23 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of five employees (on call registered nurse (OCRN)-E), unlicensed personnel (ULP)-H). 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: OCRN-E OCRN-E was hired on June 8, 2022, to provide on call registered nurse services under the licensee's Assisted Living with Dementia Care license. R2's Progress Notes dated April 5, 2023, indicated direct care staff called OCRN-E regarding R2 almost falling and was lowered to the ground. OCRN-E's employee record lacked evidence OCRN-E had completed the following orientation to assisted living topics: - an overview of this chapter (144G);	01470		

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	37315	A. BUILDING: _____ B. WING _____	06/14/2023

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01470	Continued From page 24 - 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; - 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. ULP-H ULP-H was hired on November 8, 2022, to provide direct care services under the licensee's Assisted Living with Dementia Care license. On June 12, 2023, at 5:00 p.m., the surveyor observed ULP-F bring R1 to her room. ULP-H used a scanner for the Freestyle Libre 2 (continuous glucose monitor) to scan the Freestyle Libre 2 sensor that was located on R1's upper arm. ULP-H's employee record lacked evidence ULP-H had completed the following orientation to assisted living topics: - an overview of this chapter (144G); - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 25 person; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - 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 June 14, 2023, at 10:39 a.m., regional director of operations (RDO)-C stated OCRN-E and ULP-H had not completed the above orientation to assisted living topics as indicated above. The licensee's Assisted Living with Memory Care Orientation - All Staff dated July 26, 2021, indicated orientation includes: - 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); - handling of residents' complaints, reporting of complaints, and where to report complaints,	01470		

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01470	Continued From page 26 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540		

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01540	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of five employees (unlicensed personnel (ULP)-H) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on November 8, 2022, to provide direct care services under the licensee's Assisted Living with Dementia Care license. On June 12, 2023, at 5:00 p.m., the surveyor observed ULP-F bring R1 to her room. ULP-H used a scanner for the Freestyle Libre 2 (continuous glucose monitor) to scan the Freestyle Libre 2 sensor that was located on R1's upper arm. ULP-H's employee record indicated ULP-F had completed 6.75 hours of dementia training. On June 14, 2023, at 9:53 a.m., clinical nurse supervisor (CNS)-B stated ULP-H had completed 6.75 hours of dementia training and ULP-H had worked more than 80 hours.	01540		

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01540	Continued From page 28 The licensee's Assisted Living with Memory Care Dementia Training dated July 29, 2021, indicated direct-care staff will complete a minimum of eight (8) hours training on dementia care topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=E	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 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	01620		

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01620	Continued From page 29 by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment of two of two residents (R1, R2) with skin conditions and one of one resident with falls (R3). 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: SKIN R1 R1's diagnoses included diabetes and dementia. R1's service plan dated June 12, 2023, indicated R1 received assistance with bathing, dressing, oral care, compression stockings, bed mobility, transfers using a mechanical lift, toileting, catheter care, laundry, and housekeeping. R1's Master Assessment date June 9, 2023, indicated R1 had open areas on R1's groin, buttocks, and had a rash. R1's record lacked evidence the RN had completed an assessment of the open areas identified on R1's Master Assessment dated June 9, 2023.	01620		

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01620	Continued From page 30 On June 13, 2023, at 2:50 p.m., clinical nurse supervisor (CNS)-B confirmed an assessment of R1's skin condition was not completed on June 9, 2023, when R1 returned from the TCU (transitional care unit). The surveyor observed CNS-B and regional director of operations (RDO)-C perform an assessment of R1's skin. R1's Progress Notes dated June 13, 2023, at 4:07 p.m., indicated the following: R1's right distal forearm has circular birthmark 1.5 cm (centimeter) X 1.5 cm that is slightly darker than surrounding skin with no noted redness to that area. Right dorsal hand has bruise that is from IV (intravenous fluid through a vein) from ER visit measures 1.1 cm X 1.8 cm. No swelling to the area. Noted to have slight pink skin to posterior right armpit due to moisture. Bilateral breasts have noted redness due to moisture. Medial to right breast (mid sternum) appears to have birthmark-like area that is 0.6 cm X 1.7 cm. No surrounding redness. R1 has redness to bilateral abdominal folds with right being slightly more red than the left and superficial thin skin noted to the right side. Resident has bilateral open areas to inner thighs. Noted that these areas are possibly due to catheter in this area. Left inner posterior thigh has 2 cm X 2 cm open area that is irregularly shaped with pink skin surrounding and is moist with serosanguinous drainage noted. Right inner posterior thigh has two areas noted. Medial area measures 1.6 cm X 0.9 cm and lateral area measure 1.3 cm X 1 cm with both areas open and moist with no drainage noted at this time. Defined edges for both of these areas. Has patch of dry skin noted below these two areas that is 0.7 cm X 0.5 cm. Noted that resident has a rectum skin growth measuring 1.5 cm X 1.4 cm and is the same color as surrounding skin and area is not open with irregular edges. Has chronic	01620		

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01620	Continued From page 31 dry area to right heel that is not open. Updated NP on findings of full body audit and requesting treatment orders for open areas. R2 R2's diagnoses included transient ischemic attack (TIA), congestive heart failure, hypothyroidism, and adjustment disorder with depressed mood. R2's service plan dated February 1, 2023, indicated R2 received the following services: medication administration, assistance with toileting (12:00 a.m., 4:00 a.m., 6:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 4:00 p.m., 9:00 p.m.), repositioning (2:00 a.m., 6:00 a.m., 10:00 a.m., 10:00 p.m.), dressing (twice a day), grooming (twice a day), oral care (twice a day) safety checks (10:00 p.m.), meal delivery (three times a day), and housekeeping (weekly). On June 13, 2023, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-I and ULP-J turn R2 onto R2's left side. The surveyor observed a large, discolored area (red/purple color) on R2's upper back, below neckline and upper right shoulder. No open areas were observed on R2 buttocks. ULP-I stated the discolored area had been there for some time and they were no longer putting any medicated cream on the area. R2's Master Assessment dated March 22, 2023, indicated R2 had a rash on bilateral buttocks, and open areas on R2's bilateral buttocks, related to scratching and incontinence. R2's record lacked evidence the RN had completed an assessment of the R2's skin condition to include the discolored area on R2's upper back.	01620		

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01620	Continued From page 32 On June 13, 2023, at 11:00 a.m., CNS-B stated the discolored area on R2 upper back and shoulder might be from shingles. R2 was treated for shingles in April 2023. CNS-B stated the area on R2's back and upper shoulder had not been assessed by the RN. FALLS R3 R3 was admitted on July 28, 2022 and transferred to the secured unit on March 15, 2023. R3's diagnoses included dementia, aphasia, weakness, and osteoarthritis. R3's service plan dated March 15, 2023, indicated R3 received the following services: medication management, toileting, dressing, grooming, transferring with assist of one, meals, safety checks/fall hazard, toileting, laundry, and housekeeping. R3's Master Assessment dated February 23, 2023, and March 12, 2023, indicated R3 had a change of condition/services assessment due to frequent falls, R3 required assistance of one for transfers, toileting, dressing, cueing for grooming and safety checks. R3's fall reduction plan was to reduce falls indicated the nurse would complete quarterly assessments as well as post fall to assess and update care plan to reflect interventions that promote fall prevention. No changes were made to R3's fall reduction plan. R3's Master Assessment dated June 1, 2023, indicated R3 had a change in condition/service due to a change in transfer status from a one person transfer to a two person transfer with a	01620		

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mechanical lift. R3's fall reduction plan to reduce falls indicated the nurse would complete quarterly assessments as well as post fall to assess and update care plan to reflect interventions that promote fall prevention. No changes were made R3's fall reduction plan.

The licensee's Resident Incident/Accident report dated January 11, 2023, through June 4, 2023, indicated R3 had 16 reported falls, and additional falls noted in R3's progress notes below.

JANUARY FALLS

-January 21, 2023, at 10:25 a.m., unwitnessed fall in R3's room. ULP found R3 on her knees next to her bed, bleeding noted from the right side of R3's head and ULP reported bedside table impacted R3's head. The incident investigation reported completed by CNS-B on January 23, 2023, indicated:
Resident Follow Up and Prevention: Fall Reduction Interventions Implemented: Medication review done by nurse, monitor and assist resident.
Comments: Staff to continue assisting with activities of daily living (ADLs) as directed.

-January 22, 2023, at 3:20 a.m., unwitnessed fall in R3's room. ULP responded to R3's call pendant and found R3 on the floor next to her bed, bleeding from the right side of her head. The incident investigation reported completed by CNS-B on January 23, 2023, indicated:
Resident Follow Up and Prevention: General-education and instructions provided.
Comments: Care conference with niece to discuss memory care placement for additional staff eyes on resident. Niece not interested in transferring resident to memory care at this time.

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01620	Continued From page 34 Staff to continue assisting with ADLs as directed. -January 24, 2023, at 8:05 a.m., unwitnessed fall in the dining room. The incident investigation report was completed by CNS-B January 29, 2023, indicated: Comments: Staff to continue assisting with ADLs as directed. No new fall reduction interventions implemented. FEBRUARY FALLS -February 10, 2023, at 7:30 a.m., unwitnessed fall in R3's room. ULP responded to R3 call pendant and found R3 sitting on the floor next to her bed along with pajamas and pull-up noted on the floor. The incident investigation reported completed by CNS-B on February 12, 2023, indicated: Comments: Staff to continue assisting with ADLs as directed. No new fall reduction interventions implemented. -February 12, 2023, at 4:15 p.m., unwitnessed fall in R3's room. ULP responded to R3 call pendant and found R3 kneeling on the floor at bedside. The incident investigation report was not completed by CNS-B until February 19, 2023, and indicated: new interventions included adjustment to wheelchair. Resident Follow Up and Prevention: Environmental Modifications-Wheelchair adjusted. Comments: Unknown cause to fall; however, writer completed assessment of environment and left wheelchair break found to be faulty and will not lock. Writer requested that hospice switch this out with a different wheelchair. Writer has also discussed memory care placement with niece POA who is hesitant to transition resident here and reports it will not eliminate her falls and will	01620		

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disrupt resident's routine. Niece in agreement to tour memory care; however, would like transition explained to resident to see if this will encourage resident to utilize pendant and receive staff assist with cares, writer in agreement.

-February 15, 2023, at 2:15 a.m., unwitnessed fall in R3's room. ULP found R3 at bedside. The incident investigation reported was not completed by CNS-B until March 5, 2023, and indicated:
Comments: Transfer and toileting added to care plan.

February 21, 2023, at 11:30 a.m., unwitnessed fall in R3's room. ULP found R3 on floor next to bed. The incident investigation report was not completed by CNS-B until March 1, 2023, and indicated:
Comments: Unknown cause to fall; however, writer completed assessment of environment and left wheelchair break found to be faulty and will not lock. Writer requested that hospice switch this out with a different wheelchair. Writer has also discussed memory care placement with niece POA who is hesitant to transition resident here and reports it will not eliminate her falls and will disrupt resident's routine. Niece inquiring as to why resident cannot have half rails to limit her ability to get up and writer explained that side rails cannot be used in the form of a restraint and would also likely increase resident's injury risk if she's attempting to get out/in of bed. Niece in agreement to tour memory care; however, would like transition explained to resident to see if this will encourage resident to utilize pendant and receive staff assist with cares, writer in agreement.
No new fall reduction interventions implemented.

-February 21, 2023, at 6:12 p.m., unwitnessed fall

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01620	Continued From page 36 in R3's room. ULP responded to R3's call pendant and found R3 by sitting by bedside facing the bed. The incident investigation report was completed by CNS-B on February 23, 2023, indicated: Resident Follow Up and Prevention: General-education provided to resident and family. Comments: Writer spoke with resident to utilize pendant for staff to assist during ADLs. Resident verbalizes understanding; however, writer does not anticipate that resident will comply with this, and niece notified that if fall reduction does not occur, will need to proceed with transition. -February 22, 2023, at 1:20 p.m., unwitnessed fall in R3's bathroom. ULP found R3 by sitting on the floor in front of the toilet with wheelchair nearby. The incident investigation report was completed by CNS-B on February 23, 2023, indicated: . Comments: Same comment as previous incident report noted above. No new fall reduction interventions implemented. -February 22, 2023, at 2:50 p.m., unwitnessed fall in R3's room. ULP was responding to R3's call pendant and found R3 on her knees by bedside. The incident investigation report was completed by CNS-B on February 23, 2023, indicated: Comments: Same comment as February 21, 2023 incident report. No new fall reduction interventions implemented. MARCH FALLS R3's progress notes dated March 18, 2023, indicated ULP notified the triage RN R3 had a fall and was sitting on the floor next to her door, no injuries noted. Resident's record lacked evidence an incident report or fall incident investigation was completed.	01620		

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	37315	A. BUILDING: _____ B. WING _____	06/14/2023

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NORBELLA SENIOR LIVING PRIOR L	4285 FOUNTAIN HILL DRIVE NE PRIOR LAKE, MN 55372

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01620	Continued From page 37 APRIL FALLS -April 1, 2023, at 11:15 a.m., unwitnessed fall in R3's hallway. ULP found R3's on the hallway floor next to the bathroom. The incident investigation report was completed by CNS-B on April 1, 2023, indicated: Was a reduction plan in place? Yes, memory care supervision. . Resident Follow Up and Prevention: Fall Reduction Interventions Implemented: Leave room door open when in room. Comments: Staff to continue assisting with ADLs as directed. Post monitoring fall initiated. MAY FALLS -May 2, 2023, at 11:05 a.m., unwitnessed fall in R3's bathroom. ULP found R3's sitting on the floor next to the toilet. No injuries noted. RN was present in the facility. The incident investigation report was not completed by CNS-B until May 25, 2023, indicated: Comments: Frequent faller, ULPs unable to prevent all incidents due to frequent self-transferring of resident that resident is unable to complete safely without staff assist. Post fall follow up. No new fall reduction interventions implemented. -May 3, 2023, at 1:50 p.m., unwitnessed fall in R3's room. ULP heard a noise and found R3's lying on the floor next to the bed on the mat. The incident investigation report was not completed by CNS-B until May 25, 2023, indicated: Comments: Frequent faller, ULPs unable to prevent all incidents due to frequent self-transferring of resident that resident is unable to complete safely without staff assist. Post fall follow up. No new fall reduction interventions implemented.	01620		

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01620	Continued From page 38	01620		

-R3's progress notes dated May 12, 2023, indicated ULP contacted the triage nurse and report ULP found an small open area to the top of R3's right forehead. R3 reported to ULP she had a fall the previous day. R3's record lacked a completed incident and investigation report.

On June 14, 2023, at 1:17 p.m., the surveyor requested R3's post fall risk assessments. RDO-C stated post fall risk assessments were not being completed. RDO-C stated CNS-B had been using the investigation portion of the incident report as a fall risk assessment, which was not a comprehensive assessment tool for falls.

On June 14, 2023, at 3:04 p.m., CNS-B stated after an incident report was completed, she would follow up by completing an investigation. CNS-B stated she had not been completing a comprehensive fall assessment after falls and considered the incident investigation the fall assessment. CNS-B stated the licensee had a separate fall risk assessment available in RTasks (web-based electronic health record) available to use but had only been using the incident report forms. CNS-B reviewed R3's fall reports with the surveyor and CNS-B stated new fall interventions had not been developed after each of R3's falls and confirmed R3's fall reduction interventions had remained the same in several of R3's reports. CNS-B stated R3 moved into the secured unit for more supervision and although staff could not prevent a resident from falling, R3 had a decrease in falls. CNS-B stated there were areas of improvement needed for assessing fall risk factors, developing new interventions, updating care plans, providing staff education and CNS-B was in the process of developing a new

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01620	Continued From page 39 process to reduce falls. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy revised October 27, 2023, indicated the comprehensive assessment would include the residents skin condition, risk of falls and fall history. The RN would reassess the resident on an ongoing basis including if the resident had a change of condition. The licensee's Reporting, Documenting and Reviewing Incidents Involving Residents dated July 20, 2021, indicated incidents involving residents would have a corresponding incident report follow-up completed. If the incident involved a fall, a post fall assessment) or other approved electronic source of documentation) would be completed by the RN within the next business day. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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:	01890		

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01890	Continued From page 40 Based on observation, interview, and record review, the licensee failed to ensure medications included the expiration date for time sensitive medications for one of two residents (R6). 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 June 12, 2023, at 2:30 p.m., the surveyor reviewed the locked medication carts, on the unsecured unit, with the licensed assisted living director (LALD)-A. LALD-A observed and confirmed the following: R6 had three bottles of Fluticasone Propionate nasal spray that contained a label indicating the bottles were opened on June 5, 2023, but did not indicate when the medication expired. On June 12, 2023, at 2:30 p.m., LALD-A stated all medication should be labeled with open dated and expiration date. Mayo Clinic guidelines for Fluticasone Propionate lasted revised June 1, 2023, indicated throw this medicine away after you have used 120 sprays. The licensee's Storage of Medications policy revised July 28, 2021, noted medications must be kept in its original container bearing the original prescription label with legible information stating	01890		

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01890	Continued From page 41 the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to	01950		

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01950	Continued From page 42	01950		

delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of one employees (ULP-H) with records reviewed. In addition, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for treatments one of one residents (R1) reviewed.

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

The findings include:

R1's diagnoses included diabetes, and dementia.

R1's prescriber's orders dated June 9, 2023, included blood glucose monitoring ACHS (before meals and hours of sleep).

R1's Service Plan dated June 12, 2023, indicated Free Style Sensor glucose checks four times a day.

R1's June 2023 medication administration record (MAR) indicated blood glucose check at 6:00 p.m.

On June 12, 2023, at 5:00 p.m., the surveyor observed ULP-F bring R1 to her room. ULP-H used a scanner for the Freestyle Libre 2

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01950	Continued From page 43 (continuous glucose monitor) to scan the Freestyle Libre 2 sensor that was located on R1's upper arm. The reading read HI. ULP-H reported the reading to the clinical nurse supervisor (CNS)-B. CNS-B instructed ULP-H to administer R1's regularly scheduled insulin and recheck R1's blood glucose in 15 minutes. At 5:20 p.m., ULP-H rescanned R1's Freestyle Libre 2 sensor and the reading again read HI. ULP-H was then instructed to perform a blood glucose check manually. R1's record lacked evidence the registered nurse (RN) had specified, in writing, specific instructions for performing blood glucose monitoring using a Freestyle Libre 2 monitor. ULP-H's employee record lacked documentation to indicate ULP-H had been trained by the RN and demonstrated competency on how to perform blood glucose monitoring using s Freestyle Libre 2 monitor. On June 14, 2023, at 9:53 a.m., CNS-B provided the surveyor a document titled Delegated Task: Manual VS Sensor Blood Sugar Check and Insulin Administration. The document listed the names of ULP's that had been trained by CNS-B. CNS-B stated ULP-H's name was not listed on this document. CNS-B stated R1's record lacked written specific instruction for performing blood glucose monitoring using a Freestyle Libre 2 monitor. The licensee's Delegation of Nursing Tasks policy, dated July 28, 2021, indicated the RN (registered nurse) will verify the ULP is trained, competent and is instructed in the proper methods to perform the task with respect to the specific client. The ULP will not complete any task they have not been trained on until the RN	01950		

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01950	Continued From page 44 provided the training in-person, verbally, or through other acceptable methods. The RN develop written specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for one of four residents (R1). 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	01960		

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01960	Continued From page 45 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, and dementia. R1's prescriber's orders dated June 9, 2023, included blood glucose monitoring ACHS (before meals and hours of sleep). R1's Service Plan dated June 12, 2023, indicated Free Style Sensor glucose checks four times a day. R1's June 2023 medication administration record (MAR) indicated blood glucose check at 6:00 p.m. On June 12, 2023, at 5:00 p.m., unlicensed personal (ULP)-H told R1 she was going to check her blood glucose. R1 stated you were the first person to check her blood glucose today. The surveyor observed ULP-F bring R1 to her room. ULP-H used a scanner for the Freestyle Libre 2 (continuous glucose monitor) to scan the Freestyle Libre 2 sensor that was located on R1's upper arm. The reading read HI. ULP-H reported the reading to the clinical nurse supervisor (CNS)-B. CNS-B instructed ULP-H to administer R1's regularly scheduled insulin and recheck R1's blood glucose in 15 minutes. At 5:20 p.m., ULP-H rescanned R1's Freestyle Libre 2 sensor and the reading again read HI. ULP-H was then instructed to perform a blood glucose check manually.	01960		

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01960	Continued From page 46 R1's blood glucose document indicated ULP's performed blood glucose monitoring daily on June 9, 10, 11, and 12, 2023. On June 13, 2023, at 1:21 p.m., CNS-B stated R1's blood glucose monitoring was ordered to be performed four times a day and stated R1's blood glucose was performed only one time a day. The licensee's Medication and Treatment policy dated July 282, 2023, indicated medications and treatment would be performed as ordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan.	02410		

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02410	Continued From page 47 Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained during performance of vital signs for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes and dementia. R1's service plan dated June 12, 2023, indicated R1 received the following services: vital signs on the 12th day of the month, medication management, dressing, grooming, transferring, toileting, and housekeeping. On June 12, 2023, at 4:31 p.m., unlicensed personnel (ULP)-H retrieved the thermometer, blood pressure machine, and oxygen saturation monitor from a drawer in the medication cart. ULP-H walked over to R1, who was sitting at a table on the unsecure unit with two other	02410		

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02410	Continued From page 48 residents, and performed temperature, pulse, blood pressure, and oxygen saturation monitoring. On June 12, 2023, at 5:55 p.m., clinical nurse supervisor (CNS)-B stated vital signs should not be performed in a public place with other residents present No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/13/23*
Time: 12:30:56
Report: 1004231043

Food and Beverage Establishment Inspection Report

Location:
Norbella- Prior Lake
4285 Fountain Hills Dr NE
Prior Lake, MN55372
Scott County, 70

Establishment Info:
ID #: 0036826
Risk: High
Announced Inspection: No

License Categories:
HOSP, FBLB, FBC3

Expires on: 12/31/23

Operator:
Unidine Corporation

Phone #:
ID #: 53645

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

No NEW orders were issued during this inspection.

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

FOOD SERVICE AND LICENSING VERIFICATION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY SHARON SZAMATULA.

FOOD SERVICE AT THIS ESTABLISHMENT IS PROVIDED THROUGH A 3RD PARTY SERVICE, UNIDINE. NO FOOD SERVICES ARE PROVIDED BY NORBELLA STAFF.

ESTABLISHMENT HAS BEEN LICENSED BY THE FOOD, POOLS, AND LODGING SERVICES (FPLS) SECTION, AND FUTURE INSPECTIONS WILL FALL UNDER FPLS SCHEDULE.

NO INSPECTION WAS CONDUCTED DURING FOOD SERVICE VERIFICATION.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004231043 of 06/13/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us