DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 21, 2022

Licensee
Willows & Waters Senior Living
707 Upper Meadow Lane Northwest
Rochester, MN 55901

RE: Initial License Number 408752
Health Facility Identification Number (HFID) 30801
Project Number(s) SL30801015

Dear Licensee:

On December 13, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed August 22, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective December 21, 2022.

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 22, 2022, initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 22, 2022, found not corrected at the time of the December 13, 2022, follow-up evaluation and subject to a penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up evaluation completed on December 13, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jodi Johnson, Evaluation Supervisor at 507-344-2730.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	R 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30801015 On December 12, 2022, through December 13, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 22, 2022. At the time of the survey, there were 10 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	{0 650}		

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{0 650}	Continued From page 2 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of five employees (licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and unlicensed personnel (ULP)-K). 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: LALD/LPN-A	{0 650}		

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{0 650}	Continued From page 3 LALD/LPN-A started employment on October 1, 2014. LALD/LPN-A's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-K ULP-K started employment on September 1, 2021. ULP-K's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On December 13, 2022, at 8:52 a.m. LALD/LPN-A verified the above contents were missing from ULP-K's employee record. On December 13, 2022, at 10:30 a.m. LALD/LPN-A stated she was unable to locate a performance review of herself and indicated that was 'not acceptable.' LALD/LPN-A stated the review had been completed in November by the registered nurse and stated being organized was something she needed to work on. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated employee records for each person would include: -documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided.	{0 650}		

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{0 790}	Continued From page 4	{0 790}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	{0 810}		

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{0 810}	Continued From page 5 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01730} SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	{01730}		

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{01730}	Continued From page 6 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized medication management plan included all required content for three of three residents (R3, R8, 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	{01730}		

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{01730}	Continued From page 7 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: R3 R3's diagnoses included Type 2 diabetes mellitus (too much sugar in the blood), hypertension (high blood pressure) and chronic paranoid schizophrenia (a kind of psychosis, which means your mind does no agree with reality). R3's Service Plan form dated October 20, 2022, indicated R3 received services including administration of medications. R3's Individualized Medication Management Plan dated August 22, 2022, indicated "medication administered by facility staff" and for "client specific instructions" takes medications whole and takes medications crushed in soft food, varies depending on mood. "Updates/Changes" included "the medication management record (MAR/eMAR) [electronic medical record] is updated with changes". R3's MAR dated December 2022, indicated staff were administering risperidone (an antipsychotic medication used to treat schizophrenia) 1 milligram (mg) twice per day for behavior dyscontrol and clozapine (an antipsychotic medication used to treat schizophrenia) 100 mg two tablets at bedtime for sleep. R3's Behavior/Mood Symptom Tracking Tool sheet dated December 2022, indicated "symptom" and "intervention"; however, no	{01730}		

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{01730}	Continued From page 8 specific symptoms or interventions were listed. R3's record/Individualized Medication Management Plan/MAR lacked specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of risperidone and monitoring of sleep to determine effectiveness of the medication for the use of clozapine, including specific non pharmalogical interventions to implement for behaviors/symptoms and sleep. R3's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications On December 12, 2022, at 4:00 p.m. licensed assisted living director/licensed practical nurse (LALD/LPN)-A verified no specific symptoms or interventions were listed on R3's Behavior/Mood Symptom Tracking Tool sheet. LALD/LPN-A stated the licensee was not monitoring hours of sleep for R3 and there were no documented non pharmalogical interventions for sleep listed in R3's record. Registered nurse (RN)-B was present during the interview. R8 R8's diagnoses included Type 2 diabetes mellitus. R8's Service Plan form dated October 10, 2022, indicated R8 received services including administration of medications. R8's Individualized Medication Management Plan dated August 8, 2022, indicated "medication administered by facility staff" and for "client specific instructions" takes medications whole. "Updates/Changes" included "the medication	{01730}		

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{01730}	Continued From page 9 management record (MAR/eMAR) is updated with changes". R8's MAR dated December 2022, indicated staff were administering Seroquel (an antipsychotic medication used to treat schizophrenia) 12.5 mg one time a day at 2:00 p.m.; Seroquel 12.5 mg one time a day as needed (PRN) for agitation in addition to scheduled dose; Lexapro (antidepressant medication used to treat depression and anxiety) 10 mg daily and Loperamide 2 mg take one tablet after each loose stool three times per day PRN for diarrhea. R8's Behavior/Mood Symptom Tracking Tool sheet dated December 2022, indicated "symptom" and "intervention"; however, no specific symptoms or interventions were listed. R8's record/Individualized Medication Management Plan/MAR lacked specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of Seroquel and Lexapro medications; lacked non-pharmalogical interventions to implement prior to the administration of PRN Seroquel; lacked clear parameters for hours apart for administration of PRN Seroquel and scheduled Seroquel and lacked clear parameters for hours apart for administration of Loperamide PRN three times a day. R8's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications On December 12, 2022, at 4:00 p.m. LALD/LPN-A verified no specific symptoms or	{01730}		

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{01730}	Continued From page 10	{01730}		

interventions were listed on R8's Behavior/Mood Symptom Tracking Tool sheet. LALD/LPN-A verified there were no documented non-pharmalogical interventions listed to attempt prior to the administration of PRN Seroquel and R8's MAR lacked clear parameters for hours apart the administration of Seroquel and Loperamide as above. RN-B was present during the interview.

R1
R1's diagnoses included anxiety, chronic obstructive pulmonary disease (COPD) (respiratory symptoms like breathlessness and cough), and congestive heart failure (CHF).

R1's Service Plan form dated October 19, 2022, indicated R1 received services including administration of medications.

R1's Individualized Medication Management Plan dated August 18, 2022, indicated "medication administered by facility staff" and for "client specific instructions" takes medications whole. "Updates/Changes" included "the medication management record (MAR/eMAR) is updated with changes".

R1's MAR dated December 2022, indicated staff were administering ipratropium-albuterol solution (helps breathing) 0.5-2.5/3 mg/milliliter (ml) four times a day for wheezing and two times a day PRN; sodium chloride (loosens mucus in the lungs) 0.9% nebulizer solution inhale 3 ml three times a day PRN for thickened secretions/wheezing; Nyamyc (antifungal) 1000,000 unit/gram powder three times per day PRN for rash/itching; Vanicream emollient cream topically to arms and legs for rash and itching three times per day and PRN; hydrocortisone

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{01730}	Continued From page 11 (reduces inflammation) cream 2.5 % topically twice daily PRN for psoriasis; calcipotriene cream (form of vitamin D) 0.005% topically twice daily PRN to psoriasis areas; baclofen (muscle relaxant) 5 mg PRN for painful muscle spasms; sennosides-docusate sodium (laxative) 8.6-50 mg twice daily PRN constipation. R1's record/Individualized Medication Management Plan/MAR lacked clear parameters for hours apart for administration of PRN ipratropium-albuterol solution, sodium chloride nebulizer solution, Nyamyc powder, PRN Vanicream, hydrocortisone cream, calcipotriene cream, baclofen, and sennosides-docusate sodium. R1's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications On December 12, 2022, at 4:05 p.m. LALD/LPN-A and RN-B verified R1's MAR lacked clear parameters for hours apart with the administration of PRN medications as listed above. The licensee's 7.03 Medication Management Individualized Plan dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: c. documentation of specific resident instructions relating to the administration of medications No further information was provided.	{01730}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{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 prescription medications were kept in the original container bearing the original prescription label and included the expiration date of a time-dated drug, for one of one resident (R5). 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 12, 2022, at 2:17 p.m. the surveyor observed both medication carts in the medication room with unlicensed personnel (ULP)-G. In R5's storage area within the medication cart was a pencil box that included a Lantus SoloStar insulin pen. The pen lacked a label and lacked a date the pen had been opened or when the pen would expire. ULP-G indicated the unlabeled	{01890}		

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	30801	A. BUILDING: _____ B. WING _____	R 12/13/2022

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{01890}	Continued From page 13 insulin pen was probably for R5 but was unable to verify without a label attached to the medication. ULP-G further indicated there should be an opened date identified on the insulin pen. On December 12, 2022, at 4:14 p.m. registered nurse (RN)-B confirmed insulin pens should be dated when opened and verified all medications should have labels. The manufacturer instructions for use package insert dated June 2022, instructed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's 7.36 Insulin policy dated August 1, 2021, directed to compare the information of the medication administration record (MAR) with the label on the medication container. The following information should be in all the places: -resident name -name of the medication -the strength and dosage of the medication -the route -the time that the medication is to be given -any special instructions If you cannot read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The directions on the label and the MAR should be the same. The licensee's Medications-Prescription Drugs & Prohibition policy, dated August 1, 2021, directed the prescription drug 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. No further information was provided.	{01890}		

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WILLOWS & WATERS SENIOR LIVING	**707 UPPER MEADOW LANE NW ROCHESTER, MN 55901**

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 3, 2022

Administrator
Willows & Waters Senior Living
707 Upper Meadow Lane Northwest
Rochester, MN 55901

RE: Conditional License Number SL30801015
Health Facility Identification Number (HFID) 30801
Project Number(s) SL30801015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on August 22, 2022, for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **Jaunuary 1, 2023.**

LICENSING ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in§ 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1070 - 144g.52 Subd. 10 - Right To Return - $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $9,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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 (but not both) 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.

Conditional License Issued:
MDH will issue Willows & Waters Senior Living a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Willows & Waters Senior Living is in compliance.

The following conditions apply on the conditional assisted living facility license:

d. No new substantiated maltreatment allegations: If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

e. No new admissions: Willows & Waters Senior Living will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Willows & Waters Senior Living must provide the Department:

i. A list of the names and birthdates of any individuals Willows & Waters Senior Living is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident

3. Current payment source for services
4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

f. Consultant: Willows & Waters Senior Living will contract with an RN to provide consultation concerning all resident(s) to whom Willows & Waters Senior Living provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Willows & Waters Senior Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Willows & Waters Senior Living and MDH must review the RN's credentials and approve the selection. Willows & Waters Senior Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Willows & Waters Senior Living in an effort to help Willows & Waters Senior Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Willows & Waters Senior Living will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

g. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Willows & Waters Senior Living and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;

vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

h. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Willows & Waters Senior Living to correct the violations cited during the evaluation as well as to determine the overall practice of Willows & Waters Senior Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

i. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

j. Corrective Action Plan: Willows & Waters Senior Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Willows & Waters Senior Living is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Willows & Waters Senior Living is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Willows & Waters Senior Living's assisted living facility license, and Willows & Waters Senior Living will correct violations identified during the evaluation to come into full compliance. If MDH determines Willows & Waters Senior Living is not in substantial compliance, MDH may take additional enforcement action against Willows & Waters Senior Living, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

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

If you have any questions, please contact Casey DeVries, Supervisor, directly at: 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. Initial Comments: SL30801015-0 On August 15, 2022, through August 19, 2022, and on August 22, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 11 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 17, 2022, issued for SL30801015-0, tag identification 2310. On August 17, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a widespread level 3 violation. An immediate correction order was identified on August 17, 2022, and August 18, 2022, issued for	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 SL30801015-0, tag identification 1290. On August 18, 2022, the immediacy of correction order 1290 was removed, however non-compliance remained at a widespread level 3 violation.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;	0 250		

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0 250	Continued From page 2 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure when the managerial officials who oversaw the day-to-day operations and attested they understood applicable statutes and rules, failed to implement current policies and procedures as required. 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	0 250		

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0 250	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on August 15, 2022, at approximately 3:55 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.	0 250		

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0 250	Continued From page 4 - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing	0 250		

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0 250	Continued From page 5 the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Jackelyn Seifert on May 31, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs,	0 250		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 6 including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On August 19, 2022, at approximately 2:45 p.m., LALD/LPN-A confirmed the licensee conducted background studies on employees, provided orientation, training, and competency evaluations of staff, evaluated staff performance, handled complaints regarding staff or services provided by the staff, conducted initial and ongoing resident evaluations and assessments of resident needs, orientation to and implementation of the assisted living bill of rights, conducted appropriate screenings or documentation to show that staff were free of tuberculosis, medication and treatment management, delegation of tasks by the registered nurse (RN), supervision of the RN and licensed health professionals, and supervision of unlicensed personnel performing delegated tasks, and had developed corresponding policies and procedures; however, failed to implement corresponding policies and procedures, as required.	0 250		

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

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0 250	Continued From page 7 As a result of this survey, the following orders were issued, 0250, 0430, 0480, 0485, 0490, 0550, 0630, 0640, 0650, 0660, 0680, 0700, 0720, 0730, 0790, 0810, 0900, 1070, 1290, 1370, 1380, 1460, 1500, 1530, 1550, 1560, 1610, 1620, 1640, 1730, 1760, 1770, 1790, 1880, 1890, 1910, 1940, 1950, 1960, 2240, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided	0 430		

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0 430	Continued From page 8 under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for two of two residents (R1, R3) reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at 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). Findings include: R1 and R3's records lacked evidence a uniform checklist disclosure of services was provided to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. On August 17, 2022, at 4:15 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A stated R1 and R3 had recently moved into this facility from other facilities that	0 430		

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0 430	Continued From page 9 she owned. LALD/LPN-A stated although each of the other facilities owned by LALD/LPN-A had their own license, LALD/LPN-A thought the residents could just "transfer" without completion of new admission paperwork. LALD/LPN-A verified R1 and R3 had not been provided the uniform checklist disclosure of services upon admission. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy, dated August 1, 2021, indicated the licensee would obtain written acknowledgement from the resident or resident's representative that they were provided with the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,	0 480		

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0 480	Continued From page 10 chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 11 residents residing at 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 16, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks	0 485		

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0 485	Continued From page 11 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all 11 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 August 16, 2022, at approximately 8:05 a.m., the surveyor observed a hand-written menu on the refrigerator, with breakfast, lunch, and dinner	0 485		

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0 485	Continued From page 12 meals listed for August 16, 2022, and August 17, 2022. The surveyor requested the menu for the week. On August 16, 2022, at approximately 8:45 a.m., registered nurse (RN)-B provided the menus that were posted on the refrigerator to the surveyors, and stated the menu was typically prepared two days in advance by unlicensed personnel (ULP)-D with resident involvement. RN-B stated she would then look over the menus and add fruit. RN-B verified the menu was not available or provided to residents at least one week in advance, and stated the process needed improvement. The licensee's Food Service & Menu Planning policy, undated, indicated menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide	0 490		

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0 490	Continued From page 13 reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect the licensee's 11 current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the survey on August 15, 2022, through August 17, 2022, the surveyor observed most	0 490		

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0 490	Continued From page 14 residents remained in their rooms, except to come to the dining room for meals. Occasionally two or three residents were in the common area, with the television on; however, were usually asleep in their wheelchairs or in the recliner. The surveyor observed no activities offered. On August 18, 2022, at approximately 8:10 a.m., the surveyor observed an activity calendar taped to a glass door leading into a large room with puzzles, books, games, and craft items, which indicated August 18, 2022, at 4:00 p.m., was "Nail Day." On August 18, 2022, at approximately 4:30 p.m., the surveyor observed three unlicensed personnel (ULP) sitting at the kitchen table, visiting while residents were in their rooms. When the surveyor asked about the "Nail Day" activity that was scheduled for 4:00 p.m., ULP-E stated she had asked the residents who were awake at about 2:00 p.m., if they were interested, but stated several residents were sleeping at that time. When asked if residents that were sleeping were asked after waking, ULP-E did not answer. ULP-H stated residents usually played bingo on Fridays, and there was an occasional movie shown, but otherwise activities were not routinely offered. On August 18, 2022, at approximately 4:55 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A verified the only activity that was typically provided was bingo on Fridays, and stated when staff do not offer or provide activities to the residents, "It drives me crazy." The licensee's Activity Programming policy, dated August 1, 2021, indicated a wide range of activities and social recreation would be provided	0 490		

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0 490	Continued From page 15 to the residents on "a regular basis," providing opportunities for residents and staff engagement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's 11 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 550		

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0 550	Continued From page 16 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting, in a conspicuous place, of the licensee's grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the State and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC), as required. Upon entrance to the facility, on August 15, 2022, at approximately 3:55 p.m., the surveyor observed the main entry area of the facility. A large wall to the left of the main entrance held the licensee's issued assisted living license, and the licensed assisted living director's (LALD) license; however, lacked the grievance procedure as required. On August 16, 2022, at approximately 8:45 a.m., the surveyor observed LALD/licensed practical nurse (LPN)-A taping documents on the wall near the main entrance. LALD/LPN-A confirmed the required content noted above was not posted prior to the surveyor's entrance to the facility. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about the licensee's complaint/	0 550		

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0 550	Continued From page 17 grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. The posting would also include the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities and would include information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1) reviewed.	0 630		

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0 630	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's record lacked an individual abuse prevention plan which reviewed the resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to those residents and other vulnerable adults. R1's diagnoses included major depressive disorder, type 2 diabetes, anxiety, and chronic obstructive pulmonary disease. R1's record lacked a service plan for this licensee. R1's Uniform Assessment Tool, dated June 10, 2022, indicated R1 received assistance with medication management, bathing, housekeeping, and laundry. R1's record lacked an individual abuse prevention plan, as required. The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 19 vulnerable adult and would contain an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults, the resident'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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the	0 640		

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0 640	Continued From page 20 licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and - post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On August 15, 2022, during the facility tour at approximately 4:22 p.m., the surveyor observed the entry area, common areas, kitchen and dining room within the facility and noted there was no posting of the 911 emergency number or information and the reporting number for MAARC, as required. On August 16, 2022, at approximately 8:45 a.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A confirmed the 911 emergency number and the MAARC information was not posted and available to residents, family members, and visitors to the facility. The licensee did not provide a policy regarding the above required postings.	0 640		

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0 640	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for five of six employees (director of maintenance (DM)-C, licensed assisted living director (LALD)/licensed practical nurse (LPN)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-D, ULP-H) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DM-C DM-C started employment on June 1, 2021. DM-C's record lacked evidence of the following: -documentation of annual performance reviews that identify areas of improvement needed and training needs. LALD/LPN-A LALD/LPN-A started employment on October 1, 2014. LALD/LPN-A's record lacked evidence of the following: - current signed job description, which includes qualifications, responsibilities; and	0 650		

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0 650	Continued From page 23 - documentation of annual performance reviews that identify areas of improvement needed and training needs. RN-B RN-B started employment on February 24, 2022. RN-B's record lacked evidence of the following: - current signed job description, which includes qualifications, responsibilities. ULP-D ULP-D started employment on April 28, 2021. ULP-D's record lacked evidence of the following: - current signed job description, which includes qualifications, responsibilities; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-H ULP-H started employment on June 14, 2021. ULP-H's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 19, 2022, at approximately 12:52 p.m., LALD/LPN-A verified the above contents were missing from the employees' records. The licensee's Employee Records policy, dated August 1, 2021, indicated employee records for each person would include: -evidence of current professional licensure, registration or certificate, if required; -records of all training and in-service education required and/or provided including record of	0 650		

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0 650	Continued From page 24 competency testing as required; -current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; -documentation of annual performance reviews that identify areas of improvement needed and training needs; -for individuals providing Assisted Living services, verification that required health screenings for tuberculosis have taken place and the dates of those screenings; -documentation of a completed background study; -evidence that a reference check has been completed; and -verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	0 660		

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0 660	Continued From page 25 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). This included documentation of a completed health history and symptom screening for five of six employees (director of maintenance (DM)-C, licensed assisted living director (LALD)/licensed practical nurse (LPN)-A, registered nurse (RN)-C, unlicensed personnel (ULP)-D, ULP-H) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for six of six employees (DM-C, LALD/LPN-A, RN-B, ULP-D, ULP-E, ULP-H). In addition, the licensee failed to ensure employees completed TB training for six of six employees (DM-C, LALD/LPN-A, RN-B, ULP-D, ULP-E, ULP-H). This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility Tuberculosis (TB) Risk	0 660		

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0 660	Continued From page 26 Assessment dated June 23, 2022, indicated a low risk level. DM-C DM-C started employment on June 1, 2021. DM-C's employee record lacked evidence of completed health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. LALD/LPN-A LALD/LPN-A started employment October 1, 2014. LALD/LPN-A's employee record lacked evidence of completed health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. RN-C RN-C started employment on February 24, 2022. RN-C's employee record lacked evidence of completed health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-D ULP-D started employment on April 28, 2021. ULP-D's employee record lacked evidence of completed health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required.	0 660		

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0 660	Continued From page 27 ULP-E ULP-E started employment on August 2, 2022. ULP-E's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCW), dated August 8, 2022, that included TB health history and symptom screening; however, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-H ULP-H started employment on June 14, 2021. ULP-H's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. On July 19, 2022, at approximately 12:52 p.m., LALD/LPN-A verified the above contents were missing from the employees' records. The licensee's Tuberculosis Screening policy, dated August 1, 2021, lacked identification of an individual staff member with primary responsibility for the TB infection control program. The policy indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCW's and would have a blood test or a two-step tuberculin skin test. The policy directed no staff would be permitted to begin work where the work involved sharing the air space with residents until the negative results of the blood test or the first tuberculin skin test were read and documented. In addition, staff TB screening results would be kept in each employee medical file. Further, the policy indicated staff would be educated regarding TB at the time of hire.	0 660		

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0 660	Continued From page 28 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 an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 29 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency disaster plan with the required content. 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 4:22 p.m., during a tour of the facility with registered nurse (RN)-B, the surveyor observed no information posted regarding an emergency preparedness plan throughout the common areas of the facility, and observed no emergency exit diagrams posted on the main level where resident apartments were located.	0 680		

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0 680	Continued From page 30 On August 16, 2022, at 8:05 a.m., survey staff requested to view the emergency preparedness plan. Licensed Assisted Living Director (LALD)/licensed practical nurse (LPN)-A stated director of maintenance (DM)-C had been working on it since another facility owned by the licensee had been surveyed. LALD/LPN-A stated she would check with DM-C. On August 18, 2022, at approximately 5:12 p.m., the surveyor again requested to see the emergency preparedness plan. LALD/LPN-A nodded and stated she would get it from DM-C. An August 19, 2022, at approximately 12:52 p.m., LALD/LPN-A stated there was no emergency preparedness plan completed, and verified the emergency exit diagram was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	0 700		

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0 700	Continued From page 31 Based on interview and record review, the facility failed to protect one of one resident's (R4) written record against loss. 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 August 18, 2022, at approximately 7:02 a.m., LALD/LPN-A provided a list of discharged residents since August 1, 2021, as well as the written records for those residents. LALD/LPN-A stated some documents were missing, but the majority of the records were there. When the surveyor requested to review R4's record, LALD/LPN-A stated she had "looked everywhere in the garage, in the cupboard, everywhere," but stated R4's progress notes were missing. LALD/LPN-A stated, "I have no idea where they are." On August 22, 2022, at approximately 1:04 p.m., during a telephone conversation regarding R4, LALD/LPN-A stated R4 had fallen while she was a resident in the facility. When the surveyor asked to see the incident reports for those falls, LALD/LPN-A stated she couldn't provide the incident reports for those falls because she didn't know where they were. No further information was provided.	0 700		

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0 700	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 700		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide records in a timely manner to the Minnesota Department of Health (MDH) surveyors on behalf of the commissioner, when requested. 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: Prior to entrance to the facility on August 15, 2022, after the surveyor made telephone contact with the licensee, the surveyor sent an email to licensed assisted living director (LALD)/licensed practical nurse (LPN)-A at 3:16 p.m., with requests for documents to be ready upon	0 720		

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0 720	Continued From page 33 entrance, including a list of all discharged residents for the past six months. Upon entrance to the facility on August 15, 2022, at approximately 3:55 p.m., the surveyor made a second request for documents including a list of all residents that had been discharged from the facility for the past six months. LALD/LPN-A stated she could not recall anyone that had been discharged in the past six months. The surveyor then requested a list of all residents that had been discharged since August 1, 2021, or since the assisted living licensure became effective. LALD/LPN-A stated she had an appointment at 4:30 p.m., that she needed to get to and stated she would need to "go out to the garage" to look through piles of resident records, to see if anyone had been discharged since then because she could not recall if anyone had. On August 16, 2022, at approximately 9:20 a.m., the surveyor again requested the list of discharged residents since August 1, 2021. LALD/LPN-A stated she still needed to go out to the garage to look through records, because she could not remember anyone that had been discharged. At 10:55 a.m., the surveyor asked LALD/LPN-A if she had been able to identify discharged residents as requested. LALD/LPN-A stated, "Not yet." At 4:30 p.m., the surveyor requested the list of discharged residents be available upon the surveyor's entrance the next morning. On August 17, 2022, at approximately 8:05 a.m., LALD/LPN-A stated she had yet to get out to the garage to figure out if there had been any discharged residents so she could provide the surveyor with a list. LALD/LPN-A stated she thought the surveyor had said August 1, 2022, not	0 720		

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0 720	Continued From page 34 August 1, 2021, and there had not been any discharges since then, so she did not go out to the garage to look. At 4:41 p.m., the surveyor told LALD/LPN-A that the list must be provided upon the surveyor's entrance the next morning. On August 18, 2022, at approximately 7:02 a.m., LALD/LPN-A provided a list of five residents that the licensee had discharged since August 1, 2021, as well as the written records available for those residents. The licensee's Resident Record - Access & Storage policy, dated August 1, 2021, indicated resident records would be maintained in a manner that allowed for timely access, printing, or transmission of the records, and would be made available to Minnesota Department of Health (MDH) as requested. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 720		
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	0 730		

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0 730	Continued From page 35 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R4).	0 730		

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0 730	Continued From page 36 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia, major neurocognitive disorder with behavioral disturbance, congestive heart failure, and malnutrition. R4 began receiving services on April 11, 2022, and was discharged on June 3, 2022. R4's Service Plan form, dated April 11, 2022, indicated R4 received services including assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, bathing, medication administration, hands-on assistance with transfers and mobility, laundry and housekeeping. R4's progress notes, dated June 3, 2022, indicated R4 was taken to the emergency department due to being "out of control." R4's progress note on June 4, 2022, indicated R4's family member called the facility asking about R4 being able to return to the facility. Registered nurse (RN)-B documented she suggested R4 "would probably do well," at a facility that provided "24/7 nurse on site." There were no further progress notes; however, R4 did not return to the facility.	0 730		

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0 730	Continued From page 37 R4's record lacked evidence a discharge summary was completed. On August 18, 2022, at approximately 7:28 a.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A verified the licensee did not complete a discharge summary. The licensee's Resident Discharge Summary form, undated, directed the resident's discharge summary would include a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results. In addition, the discharge summary would include a final summary of the resident's status from the latest assessment or review, a reconciliation of all pre-discharge medications, and a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790		

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0 790	Continued From page 38 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document monthly fire extinguisher inspections. This has the potential to directly affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August 17, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with director of maintenance (DM)-C. During the facility tour, survey staff noted that monthly fire extingusher inspections were not being documented on the fire extinguisher inspection tag or other inspection log. DM-C verbally confirmed survey staff findings during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 790		

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0 810	Continued From page 39	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct staff and resident	0 810		

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0 810	Continued From page 40 training and conduct fire drills as required. This has the potential to directly affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August 17, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with director of maintenance DM-C. During the facility tour, survey staff noted that fire drill documentation could not be located to show that fire drills were being conducted as required. There was no documentation available to review to show fire drills were completed during the the past year. DM-C verbally confirmed survey staff findings during the facility tour. On August 17, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with owner DM-C. During the facility tour, survey staff noted that the fire emergency plan did not describe procedures for resident movement evacuaution or reloactoion during fire or similar emergencies. DM-C verbally confirmed survey staff findings during the facility tour.	0 810		

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0 810	Continued From page 41 On August 17, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with owner DM-C. During the facility tour, survey staff noted that there was no documentation or records to show that staff had recieved fire safety training during employee orientation and thereafter every two years. DM-C verbally confirmed survey staff findings during the facility tour. On August 17, 2022, from approximately 10:30 a.m. to 12:30 p.m., survey staff toured the facility with director of maintenance DM-C. During the facility tour, survey staff noted that there was no documentation or records to show that residents had receivd training of what they should do in the event of a fire emergency including movement, evacuation, or relocation. DM-C verbally confirmed survey staff findings during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	0 900		

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0 900	Continued From page 42 (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for 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 pattern scope (when more than a limited number of residents are affected, more	0 900		

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0 900	Continued From page 43 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 and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, the resident records lacked evidence the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On August 16, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A stated R1 and R3 were admitted to this facility from two other facilities that the licensee owned, and they thought the contract the residents had signed at the previous facility, could be used for this facility. The licensee's Signing An Assisted Living Contract policy, dated August 1, 2021, indicated when a prospective resident decided to move into the facility, an Assisted Living contract would be signed and received by the facility.	0 900		

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0 900	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01070 SS=G	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow one of one resident (R4) to return to the facility after hospitalization, without effectuation of a termination of housing. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: Prior to and upon entrance to the facility on August 15, 2022, at 3:55 p.m., the surveyor requested, verbally and through email, a list of residents that the licensee had discharged from the facility since the assisted living licensure became effective on August 1, 2021. Licensed	01070		

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01070	Continued From page 45	01070		

assisted living director (LALD)/licensed practical nurse (LPN)-A stated she would have to "go out to the garage to look through records," to determine if any residents had been discharged during that timeframe, because she could not recall that anyone had been discharged. The list was not readily provided, and the surveyor continued to request a list of discharged residents several times throughout the day on August 16, 2022, and August 17, 2022.

On August 18, 2022, at approximately 7:02 a.m., LALD/LPN-A provided a discharged resident roster, which included five residents, with R4 being the most recent discharge, on June 3, 2022. The surveyor requested to review R4's record which LALD/LPN-A provided. LALD/LPN-A stated, although she had R4's record, she looked everywhere and could not locate R4's progress notes.

R4's record indicated R4 was admitted to the facility on April 11, 2022, with diagnoses including dementia, major neurocognitive disorder with behavioral disturbance, congestive heart failure, frailty and debility, anemia, and back pain.

R4's Service Plan, dated April 11, 2022, indicated R4 required assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, bathing, medication administration, hands-on assistance with transfers and mobility, laundry, housekeeping, safety checks, and oxygen management.

R4's Housing With Services (licensee is an assisted living facility, not housing with services) Contract (Lease), dated April 11, 2022, indicated the term of the contract was for one year; however, a handwritten note indicated, "If this is

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01070	Continued From page 46	01070		

not a good fit, we will prorate stay. Not obligated monthly." The contract also included, the licensee would "give a 30-day + 1 notice in writing if we choose to terminate our contract with a tenant."

R4's admission assessment, dated April 11, 2022, indicated R4 was resistant to cares/medications, withdrawn, had verbal and physical aggression, hostility, defiance, angry outbursts, and was cursing and swearing. The assessment also indicated R4 was at risk for falling and was a high elopement risk, although a handwritten note documented, "does not exit seek."

R4's progress notes, included an admission note on April 11, 2022; however, lacked any other progress notes until June 3, 2022, with no time notation, which included documentation by LALD/LPN-A, indicating she had received a telephone call from facility staff stating R4 was "out of control," and they had tried interventions such as redirection, music, placing her in her room to watch her favorite shows, and had taken her for a walk around the facility in her wheelchair. Staff reported R4 was screaming and kicking for 45 minutes, kicking and hitting at staff and another resident. LALD/LPN-A notified the licensee's registered nurse ((RN)-B) and she advised that R4 "be seen," to rule out a urinary tract infection (UTI) and to determine the cause of her behavior. Licensee staff called 911, and R4 was transferred by ambulance to the emergency department (ED). The note indicated RN-B would notify R4's power of attorney (POA). Another progress note dated June 3, 2022, at 2:30 p.m., indicated R4's family member (FM)-I called the facility to inquire if R4 had a bowel movement that day and whether or not R4 had eaten lunch.

R4's progress note, dated June 4, 2022, written

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01070	Continued From page 47 by RN-B, indicated she had received a call from FM-I, asking about R4 returning to the facility. RN-B documented they discussed, at length, whether the licensee's staff was "really adequate" to meet R4's needs and RN-B told FM-I that R4 would probably do well at a facility that provided a nurse on-site "24/7 [24 hours a day, 7 days a week]." RN-B documented FM-I asked for suggestions and RN-B provided the name of another facility. There were no further progress notes. On August 19, 2022, at approximately 2:55 p.m., during a telephone interview, FM-I stated facility staff notified her of R4's transfer to the ED on June 3, 2022, after R4 had already been transferred, and FM-I met R4 in the ED. While there, FM-I stated she was informed by an ED nurse, that the licensee had called for a status update on R4 and was informed R4 had a UTI, and would be treated with an antibiotic. FM-I stated the ED nurse told her the licensee refused to allow R4 to return to the facility. FM-I stated, because R4 was not allowed to return to the facility, she was admitted and spent four weeks in the hospital, waiting for an opening at a different facility. FM-I stated R4, nor her representatives received a written notice of the termination of the contract, as required. During a telephone interview with LALD-A and RN-B on August 22, 2022, at approximately 1:04 p.m., LALD/LPN-A stated R4 was "pretty good" when she was first admitted, but within a week, she started "needing more attention." LALD/LPN-A stated R4 needed 1:1 supervision at times, would holler at night and keep other residents awake, would self-propel her wheelchair, and bang into walls and residents, and tried to elope through a side door.	01070		

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WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

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01070	Continued From page 48 LALD/LPN-A stated they had a family care conference on May 23, 2022, with family members present and, on the telephone, and they discussed R4's wheelchair activity because the family did not want the resident's wheels to be locked and wanted her to be able to self-propel. LALD/LPN-B stated R4 had a fall, and family members were upset because they felt R4's wheelchair should have prevented the fall, if used correctly. The surveyor asked to see the fall report; however, LALD/LPN-A stated she could not locate R4's fall reports. LALD/LPN-A and RN-B stated they discussed R4's behaviors with her family; however, did not discuss terminating the contract. When the surveyor asked if the the licensee ever initiated the required termination process, RN-B stated she was concerned because the licensee was not staffed adequately to be able to provide the level of care that R4 needed. In addition, LALD/LPN-A indicated the Office of Ombudsman for Long-Term Care was not notified, as required. The facility's Resident Right to Return policy, dated August 1, 2021, included, if a resident is absent from the facility for any reason, including an emergency relocation, the facility will not refuse to allow a resident to return if a termination of housing has not been effectuated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01070		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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01290	Continued From page 49 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for three of six employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, 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 August 17, 2022, at approximately 4:41 p.m., the surveyor requested personnel records to review for compliance during the next day of the survey. Licensed assisted living director	01290	On August 18, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a widespread level 3 violation.	

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01290	Continued From page 50 (LALD)/licensed practical nurse (LPN)-A stated she was aware of the required contents of the employee records; however, stated she knew that some things were missing from the records. LALD/LPN-A indicated ULP-D and ULP-E's background study clearance letters were not in their employee records because they weren't received yet from the Department of Human Services (DHS) and stated she would have to check all the current employee records to ensure no other background study clearances were missing. LALD/LPN-A stated Director of Maintenance (DM)-C had been on the phone with DHS for an extended amount of time during the day, attempting to get copies of the missing background clearances, but stated the representative from DHS told DM-C that they were more than two months behind and could not provide the background clearances. ULP-D ULP-D was hired to provide assisted living services to the licensee's residents; however, her hire date could not be confirmed. The licensee provided the surveyor with three different dates, including April 25, 2021, March 27, 2022, and April 28, 2022. On August 15, 2022, at approximately 4:22 p.m., the surveyor observed the white board in the dining room that listed the staffing schedule for the day, and noted ULP-D worked from 7:00 a.m., to 3:00 p.m., at the facility. On August 16, 2022, at approximately 8:00 a.m., the surveyor observed the white board in the dining room that listed the staffing schedule for the day, and noted ULP-D worked from 7:00 a.m., to 3:00 p.m. The surveyor observed ULP-D throughout the shift while interacting with	01290		

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01290	Continued From page 51 residents, independently going in and out of resident rooms, and serving meals to residents. ULP-D's employee record lacked a background study clearance letter for ULP-D. On August 18, 2022, at approximately 10:40 a.m., DM-C stated he was not sure of ULP-D's exact hire date; however, ULP-D had worked in another facility that the licensee owned which closed last year. Since beginning employment at this facility, DM-C stated ULP-D had been disqualified (from working with vulnerable adults) and was working on appealing it. DM-C provided the following documentation from DHS, that he printed from the website: -A Notice of Background Study Disqualification, dated August 24, 2021, addressed to the licensee with ULP-D's name, indicating ULP-D was "disqualified from any position with direct contact, or access to people that receive services from all entit(ies) under your organization." The letter included, "You must immediately remove [ULP-D] from any position with direct contact, or access to, people receiving services pending a possible reconsideration decision. You cannot return [ULP-D] to a position with direct contact, or access to people served by all entit(ies) under your organization unless you receive notice that his/her disqualification is set aside or rescinded." Also included, "The Background Studies Division has reviewed the information immediately available and determined that [ULP-D] poses a risk of harm. You may not allow her to provide direct contact services pending a possible reconsideration decision." -A Notice of Background Study Disqualification, dated November 22, 2021, addressed to the	01290		

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01290	Continued From page 52 licensee with ULP-D's name, indicating ULP-D was disqualified from any position with direct contact, or access to people that receive services from all entit(ies) under this organization. Also included, "The Background Studies Division has reviewed the information immediately available and determined that [ULP-D] poses a risk of harm. You may not allow her to provide direct contact services pending a possible reconsideration decision." Actions required included ULP-D had 15 days to request reconsideration, and directed, "Immediately remove [ULP-D] if you are notified by NETStudy 2.0 [online system for submitting background studies] that she did not request reconsideration." -A Notice of Background Study Disqualification, dated February 15, 2022, addressed to the licensee with ULP-D's name, indicating ULP-D was disqualified from any position with direct contact, or access to people that receive services from all entit(ies) under the organization. Action required included ULP-D was given 30 days to request reconsideration, the licensee should ensure ULP-D was under continuous, direct supervision when providing direct contact services, and directed to immediately remove ULP-D if notified by NETStudy 2.0 that she did not request reconsideration. An additional DHS Background Study Notice, dated April 5, 2022, obtained by the Minnesota Department of Health (MDH) from NETStudy, was addressed to ULP-D and identified the licensee's name, included, "A REQUEST FOR RECONSIDERATION OF YOUR DISQUALIFICATION WAS NOT RECEIVED IN THE TIME REQUIRED. The entity must immediately remove you from your position." The document further indicated ULP-D failed to	01290		

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01290	Continued From page 53	01290		

request reconsideration of the disqualification within the time required, and included, "You cannot have any job where you would provide direct contact services and a DHS background study is required. In a nursing home or boarding care home, you are not permitted to have any job or position."

A DHS Background Study Notice, dated April 27, 2022, obtained by MDH from NETStudy, identified ULP-D's name, indicated the licensee requested background study status.

On August 18, 2022, at approximately 11:40 a.m., DM-C stated ULP-D continued to work for the licensee and to perform assisted living services, because the licensee was trying to help her to get her background study reconsidered and cleared. DM-C stated she had everything together that she needed to provide for reconsideration, but missed the deadline date, so they kept having to start the process over again. When asked why they continued to allow her to work in the facility with the disqualification letters they continued to receive, DM-C stated they thought as long as they had someone else in the building while she was here, that she was being "supervised." DM-C stated he didn't realize that continuous, direct supervision meant they needed to "hold her hand."

On August 18, 2022, at approximately 12:01 p.m., DM-C provided a summary of ULP-D's timecards from February 15, 2022, through August 16, 2022, which indicated ULP-D worked 127 shifts, mostly day and evenings where at least two staff were in the facility; however, noted were two shifts on March 23, 2022, and April 2, 2022, that were overnight shifts where only one staff was in the facility.

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01290	Continued From page 54 On August 18, 2022, at 12:17 p.m., LALD/LPN-A verified that one staff worked the overnight shift, therefore, ULP-D would have been working alone on March 23, 2022, and April 2, 2022. ULP-E ULP-E had a hire date of August 2, 2022, to provide assisted living services to the licensee's residents. ULP-E's employee record lacked a background study clearance letter for ULP-E. On August 17, 2022, at approximately 8:05 a.m., the surveyor observed the white board in the dining room that listed the staffing schedule for the day, and noted ULP-E worked 7:00 a.m., to 3:00 p.m. Throughout the day, the surveyor observed ULP-E interacting with residents, independently going in and out of resident rooms, and working in the kitchen to prepare meals and serve meals to the residents. On August 18, 2022, at approximately 7:00 a.m., the white board in the dining room noted ULP-E worked from 7:00 a.m., to 3:00 p.m., with ULP-G. LALD/LPN-A was present and stated she had spoken to ULP-E and ULP-G, and directed them to work together so that ULP-E would be supervised during resident contact due to ULP-E's background clearance not being completed. At 7:28 a.m., the surveyor observed ULP-G in the kitchen; however, ULP-E was not with her. The surveyor observed ULP-E in a resident's room, in the bathroom, providing personal cares to the resident. ULP-F ULP-F had a hire date of June 10, 2022, to	01290		

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01290	Continued From page 55 provide assisted living services to the licensee's residents. ULP-F's employee record lacked a background study clearance letter for ULP-F. On August 18, 2022, at approximately 7:10 a.m., LALD/LPN-A stated she had been at the facility all night because she realized that ULP-F, who worked the night shift, did not have a background clearance, and needed to be supervised during resident contact. On August 18, 2022, at approximately 7:38 a.m., DM-C, who also works with the licensee's employee records, discussed frustration with the background study process and DHS. DM-C stated he was working on ensuring the employees had a background study, and was in the process of completing this. The licensee's Background Studies policy, dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at the facility. The policy indicated, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received." Also included, if hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to residents except under direct supervision (eyesight) of another qualified staff person. The policy also included an individual with a background study result that identified that the individual was disqualified from any position	01290		

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01290	Continued From page 56 allowing direct contact with or access to, people receiving services, will not be employed by the licensee. Further, copies of the completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a	01370		

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01370	Continued From page 57 licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-H, ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H was hired on June 14, 2021, to provide direct care services to residents of the facility. On August 16, 2022, at approximately 12:24 p.m.,	01370		

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01370	Continued From page 58 the surveyor observed while ULP-H prepared to check R5's blood sugar. ULP-H donned gloves, put the strip into the glucometer, and watched as R5 poked her own finger and placed a drop of blood onto the testing strip. ULP-H documented the results and retrieved R5's Novolog Flex Pen from the medication cart. ULP-H primed the insulin pen and then dialed it to the prescribed dose of insulin. ULP-H handed the insulin pen to R5, and R5 self-administered the insulin and went to lunch. ULP-H's employee record lacked documentation of training and competency evaluations for the following: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural	01370		

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01370	Continued From page 59 background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired on April 28, 2021, to provide direct care services to residents of the facility. On August 16, 2022, at 12:07 p.m., the surveyor observed ULP-D serving the lunch meal, interacting with residents. ULP-D's employee record lacked documentation of training for the following topics: - standby assistance techniques and how to perform them. On August 19, 2022, at approximately 12:30 p.m., registered nurse (RN)-B stated she had not provided any formal training to the ULP in this facility. RN-B stated she had asked newer employees to sign off on things that they felt comfortable doing, but had not gotten to training or evaluating them yet. The licensee's Competency Training Evaluations policy, dated August 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and	01370		

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01370	Continued From page 60 skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP will include: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. No further information was provided.	01370		

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01370	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-H, ULP-D) to include all required content. 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	01380		

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01380	Continued From page 62 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H was hired on June 14, 2021, to provide direct care services to residents of the facility. On August 16, 2022, at approximately 12:24 p.m., the surveyor observed while ULP-H prepared to check R5's blood sugar. ULP-H donned gloves, put the strip into the glucometer, and watched as R5 poked her own finger and placed a drop of blood onto the testing strip. ULP-H documented the results and retrieved R5's Novolog Flex Pen from the medication cart. ULP-H primed the insulin pen and then dialed it to the prescribed dose of insulin. ULP-H handed the insulin pen to R5, and R5 self-administered the insulin and went to lunch. ULP-H's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required.	01380		

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01380	Continued From page 63 ULP-D ULP-D was hired on April 28, 2021, to provide direct care services to residents of the facility. On August 16, 2022, at 12:07 p.m., the surveyor observed ULP-D serving the lunch meal, interacting with residents. ULP-D's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: - observing, reporting, and documenting resident status. On August 19, 2022, at approximately 12:30 p.m., registered nurse (RN)-B stated she had not provided any formal training to the ULP in this facility. RN-B stated she had asked newer employees to sign off on things that they felt comfortable doing, but had not gotten to training or evaluating them yet. The licensee's Competency Training Evaluations policy, dated August 1, 2021, indicated prior to the registered nurse delegating services, they must make certain the ULP is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. In addition, the policy directed only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. Training and competency evaluations for all ULP providing assisted living services must include: - observing, reporting, and documenting resident status;	01380		

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01380	Continued From page 64 - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. 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 licensing requirements and regulations was provided prior to providing assisted living services to residents for two of four employees (unlicensed personnel (ULP)-H,	01460		

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01460	Continued From page 65 registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H ULP-H had a hire date of June 14, 2021, and began providing direct care services under the licensee's assisted living license on August 1, 2021. On August 16, 2022, at approximately 12:24 p.m., the surveyor observed while ULP-H prepared to check R5's blood sugar. ULP-H donned gloves, put the strip into the glucometer, and watched as R5 poked her own finger and placed a drop of blood onto the testing strip. ULP-H documented the results and retrieved R5's Novolog Flex Pen from the medication cart. ULP-H primed the insulin pen and then dialed it to the prescribed dose of insulin. ULP-H handed the insulin pen to R5, and R5 self-administered the insulin and went to lunch. RN-B RN-B had a hire date of February 24, 2022, to provide and supervise direct care services under the licensee's assisted living license. The surveyor observed RN-B throughout the	01460		

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01460	Continued From page 66 survey, providing direct care and interacting with the licensee's residents. ULP-H and RN-B's records lacked evidence orientation was completed for the following topics: - an overview of the appropriate Assisted Living statutes and rules; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and 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 August 18, 2022, at approximately 12:15 p.m., licensed assisted living director (LALD)/licensed	01460		

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01460	Continued From page 67 practical nurse (LPN)-A verified ULP-H and RN-B had not completed orientation training for this licensee. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of the licensee providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. Orientation must be completed once for each staff person and is not transferable to another "home care provider." Also, the policy directed, "All licensee employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents" and would contain the above listed topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 68 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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	01500		

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01500	Continued From page 69 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (licensed assisted living director (LALD)/licensed practical nurse (LPN)-A, 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: LALD/LPN-A LALD/LPN-A had a hire date of October 1, 2014, and began providing direct care services under the licensee's assisted living license on August 1, 2021. The surveyor observed LALD/LPN-A providing direct care services to the licensee's residents throughout the survey. ULP-H ULP-H had a hire date of June 14, 2021, and	01500		

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01500	Continued From page 70 began providing direct care services under the licensee's assisted living license on August 1, 2021. On August 16, 2022, at approximately 12:24 p.m., the surveyor observed while ULP-H prepared to check R5's blood sugar. ULP-H donned gloves, put the strip into the glucometer, and watched as R5 poked her own finger and placed a drop of blood onto the testing strip. ULP-H documented the results and retrieved R5's Novolog Flex Pen from the medication cart. ULP-H primed the insulin pen and then dialed it to the prescribed dose of insulin. ULP-H handed the insulin pen to R5, and R5 self-administered the insulin and went to lunch. LALD/LPN-A and ULP-H's employee training records lacked evidence they had completed annual training as required, in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500		

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01500	Continued From page 71 -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 18, 2022, at approximately 12:15 p.m., LALD/LPN-A verified she and ULP-H lacked evidence of annual training. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff performing direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, and must include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557. 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. 5. Review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	Continued From page 72 and how to implement those policies and procedures. 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. The policy also indicated the licensee would retain a training record in the employee records to track compliance with annual training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530		

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01530	Continued From page 73 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure four of four employees (licensed assisted living director (LALD)/licensed practical nurse (LPN)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-D, 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 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 provided services under an assisted living license. During the entrance conference on August 15, 2022, at approximately 3:55 p.m., licensed assisted living director LALD/LPN-A stated the licensee had no current residents with the diagnosis of dementia; however, had the potential to care for residents with a dementia diagnosis. LALD/LPN-A, RN-B, ULP-D, and ULP-H's	01530		

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01530	Continued From page 74 records lacked evidence of receiving any dementia training, as required. LALD/LPN-A LALD/LPN-A started employment on October 1, 2014, and began providing assisted living services on August 1, 2021. LALD/LPN-A reached 120 working hours on October 22, 2022. LALD/LPN-A's employee record contained no dementia care training, therefore, lacked evidence the required 8 hours of dementia care training within 120 working hours, as required for supervisors of direct care staff and lacked evidence of at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. RN-B RN-B had a start date of February 24, 2022, to provide and supervise direct care services under the licensee's assisted living license. RN-B reached 120 working hours on August 15, 2022. RN-B's employee record contained no dementia care training, therefore, lacked evidence of the required 8 hours of dementia care training within 120 working hours, as required for supervisors of direct care staff. ULP-D ULP-D had a start date of April 28, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D reached 160 working hours on September 11, 2021. ULP-D's employee record contained no dementia care training, therefore, lacked evidence of the required 8 hours of dementia care training within	01530		

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01530	Continued From page 75 160 working hours, as required for direct care staff and lacked evidence of at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. ULP-H ULP-H had a hire date of June 14, 2021, and began providing direct care services under the licensee's assisted living license on August 1, 2021. ULP-H reached 160 working hours on January 7, 2022. ULP-H's employee record contained no dementia care training, therefore, lacked evidence of the required 8 hours of dementia care training within 160 working hours, as required for direct care staff and lacked evidence of at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On August 18, 2022, at approximately 12:15 p.m., LALD/LPN-A confirmed the employee records lacked evidence of the required dementia care training. The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff were required to complete dementia training at the time of hire and annually thereafter. The policy directed supervisors of direct care staff would complete 8 hours of initial training within 120 hours of the employment start date, and direct care employees would complete 8 hours of initial training within 160 hours of the employment start date. Further, the policy indicated all staff would complete two hours of additional training for each 12 months of work thereafter. No further information was provided.	01530		

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01530	Continued From page 76 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for one of one employee (director of maintenance (DM)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license.	01550		

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01550	Continued From page 77 During the entrance conference on August 15, 2022, at approximately 3:55 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A stated the licensee had no current residents with the diagnosis of dementia; however, had the potential to care for residents with a dementia diagnosis. DM-C started employment on June 1, 2021. DM-C reached 160 working hours on August 2, 2021. DM-C's record lacked evidence of receiving any dementia training, therefore, lacked evidence of the four hours of initial training within 160 working hours, as required and lacked evidence of at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On August 18, 2022, at approximately 12:15 p.m., LALD/LPN-A confirmed DM-C's employee record lacked evidence of the required dementia care training. The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff were required to complete dementia training at the time of hire and annually thereafter, and identified non-direct care staff would complete four hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		

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01560	Continued From page 78	01560		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01560		

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01560	Continued From page 79 The findings include: The licensee provided services under an assisted living license. During the entrance conference on August 15, 2022, at approximately 3:55 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A stated the licensee had no current residents with the diagnosis of dementia; however, had the potential to care for residents with a dementia diagnosis. On August 19, 2022, at approximately 8:59 a.m., LALD/LPN-A stated she could not find the written statement describing the licensee's dementia care training program and stated it must have been omitted from resident's handbook. The licensee's Dementia Training policy, dated August 1, 2021, indicated the licensee would provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01610		

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01610	Continued From page 80 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment using the uniform assessment tool for one of two residents (R3) as required. 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 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: R3 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022. R3's diagnoses included paranoid schizophrenia,	01610		

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01610	Continued From page 81 bipolar disorder, abnormal gait, and diabetes. R3's record lacked evidence of execution of a written contract. R3's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R3's Uniform Assessment Tool, dated April 10, 2022, and completed by the previous facility, indicated R3 was resistive to cares, was verbally aggressive, defiant, and displayed inappropriate sexual behavior. Also included, R3 required full assistance with housekeeping and laundry, incontinence, bathing, mobility, transfers, eating, and making transportation arrangements. Further, a handwritten note on July 6, 2022, indicated R3 had moved from the "Plummer House" to the licensee and had adjusted well to the move. R3's record lacked evidence a nursing assessment by an RN was conducted prior to the date on which a contract was executed with the facility or the date on which R3 moved in, whichever was earlier. On August 17, 2022, at approximately 1:56 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and RN-B stated R3 and three other residents moved to the facility from another facility owned by the licensee that was closing, on June 14, 2022, and a fifth resident had moved to the facility from a third facility owned by the licensee, on June 10, 2022. LALD/LPN-A stated she was not aware that the residents required all new paperwork upon admission, including an initial nursing assessment.	01610		

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01610	Continued From page 82 The licensee's Assessment Schedules grid, dated August 1, 2021, indicated a registered nurse would complete an initial nursing assessment prior to the date on which a prospective resident executed a contract with the facility or the date on which a resident moves in, whichever is earlier, and must be conducted in person or via telecommunications if necessitated by geographic distance or urgent/unexpected circumstances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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	01620		

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01620	Continued From page 83 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services as required 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 15, 2022, at approximately 3:55 p.m., RN-B stated her understanding was nursing assessments should be completed upon admission, 14 days later, and then quarterly or when there was a change in condition. R1 and R3's records lacked evidence the RN completed a comprehensive reassessment no more than 14 days after the initiation of services, as required. R1 R1 was admitted to the licensee for services,	01620		

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01620	Continued From page 84 from another facility owned by the licensee, on June 10, 2022. R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked evidence of execution of a written contract. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's record lacked evidence a nursing reassessment and monitoring was conducted by an RN no more than 14 calendar days after initiation of services, as required. R3 R3 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022. R3's diagnoses included paranoid schizophrenia, bipolar disorder, abnormal gait, and diabetes. R3's record lacked evidence of execution of a written contract. R3's record lacked evidence of a service plan	01620		

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01620	Continued From page 85 documenting agreement on the services to be provided by the licensee. R3's Uniform Assessment Tool, dated April 10, 2022, and completed by the previous facility, indicated R3 was resistive to cares, was verbally aggressive, defiant, and displayed inappropriate sexual behavior. Also included, R3 required full assistance with housekeeping and laundry, incontinence, bathing, mobility, transfers, eating, and making transportation arrangements. Further, a handwritten note on July 6, 2022, indicated R3 had moved from the "Plummer House" to the licensee and had adjusted well to the move. R3's record lacked evidence a nursing reassessment and monitoring was conducted by an RN no more than 14 calendar days after initiation of services, as required. On August 17, 2022, at approximately 1:56 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and RN-B stated R3, and three other residents, had moved to the facility from another facility owned by the licensee that was closing, on June 14, 2022, and a fifth resident had moved to the facility from a third facility owned by the licensee, on June 10, 2022. LALD/LPN-A stated she was not aware that the residents required all new paperwork upon admission, including reassessment and monitoring no more than 14 calendar days after the initiation of services. The licensee's Assessment Schedules grid, dated August 1, 2021, indicated a registered nurse would complete a resident reassessment and monitoring no more than 14 days after the initiation of services.	01620		

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01620	Continued From page 86 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided, for	01640		

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01640	Continued From page 87 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 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 and R3's records lacked evidence the licensee had finalized a current written service plan no later than 14 calendar days after the date that services were first provided, as required. R1 R1 was admitted to the licensee for services, from another facility owned by the licensee, on June 10, 2022. R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked evidence of execution of a written contract. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing.	01640		

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01640	Continued From page 88 R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R3 R3 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022. R3's diagnoses included paranoid schizophrenia, bipolar disorder, abnormal gait, and diabetes. R3's record lacked evidence of execution of a written contract. R3's Uniform Assessment Tool, dated April 10, 2022, and completed by the previous facility, indicated R3 was resistive to cares, was verbally aggressive, defiant, and displayed inappropriate sexual behavior. Also included, R3 required full assistance with housekeeping and laundry, incontinence, bathing, mobility, transfers, eating, and making transportation arrangements. Further, a handwritten note on July 6, 2022, indicated R3 had moved from the "Plummer House" to the licensee and had adjusted well to the move. R3's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. On August 17, 2022, at approximately 1:56 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and RN-B stated R3, and three other residents, had moved to the facility from another facility owned by the licensee that was closing, on June 14, 2022, and R1 had moved to the facility from a third facility owned by	01640		

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01640	Continued From page 89 the licensee, on June 10, 2022. LALD/LPN-A stated she was not aware that the residents required all new paperwork upon admission, including a current written service plan no later than 14 calendar days after the initiation of services. The licensee's Service Plan policy, dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place, based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences, with 14 days after the date that services are first provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 90 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, 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), and was issued at a	01730		

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01730	Continued From page 91 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 15, 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided medication management services to the licensee's residents, including storage of medications. R1 and R3's records lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse	01730		

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01730	Continued From page 92 reactions. R1 R1 was admitted to the licensee for services, from another facility owned by the licensee, on June 10, 2022. R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked evidence of execution of a written contract. R1's prescriber orders, revised June 10, 2022, included one pain reliever, one medication to treat gout, one antianxiety, three supplements, and topical pain gel. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's Uniform Assessment Tool included a section titled "Review of Medications;" however, was blank with a handwritten note that directed, "See med [medication] list for June 2022," with initials and dated June 10, 2022. Also included, R1 preferred to take medications whole and indicated R1 was "UNABLE" to safely self-administer medications. R1's record lacked an individualized medication management plan that included the above content. R3	01730		

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01730	Continued From page 93 R3 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022. R3's diagnoses included paranoid schizophrenia, bipolar disorder, abnormal gait, and diabetes. R3's record lacked evidence of execution of a written contract. R3's record lacked current prescriber orders. R3's record included a Medication Assessment and Management Plan, dated September 28, 2020; however, was completed at a previous facility. R3's Uniform Assessment Tool, dated April 10, 2022, and completed by the previous facility, indicated R3 was resistive to cares, was verbally aggressive, defiant, and displayed inappropriate sexual behavior. Also included, R3 required full assistance with housekeeping and laundry, incontinence, bathing, mobility, transfers, eating, and making transportation arrangements. R3's Uniform Assessment Tool included a section titled "Review of Medications;" however, was blank with a handwritten note that directed, "See med [medication] list for July 2022," with initials and dated July 6, 2022. Also included, R3 was deemed "UNABLE" to safely self-administer medications. R3's record lacked a current individualized medication management plan that included the above content. On August 19, 2022, at approximately 2:30 p.m., RN-B verified R1 and R3's records lacked a current individualized medication management	01730		

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01730	Continued From page 94 plan with the above required content and stated five residents had transferred to the facility from other facilities owned by the licensee and she wasn't aware that paperwork completed at the prior facility could not transfer to this facility. In addition, RN-B stated she had not spent much time at this facility, so she had not been able to ensure residents had the required documentation with the required content. The licensee's Medication Management Individualized Plan, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 95 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure each medication administered was documented to include the required content, failed to ensure documentation of staff signatures who administered medications, and failed to include reason why medication administration was not completed for one of one resident (R1). In addition, the licensee failed to ensure physician orders were transcribed accurately for one of two residents (R5). 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: During the entrance conference on August 15, 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided medication management services to the licensee's residents. DOCUMENTATION OF MEDICATION ADMINISTRATION R1 R1's diagnoses included major depressive	01760		

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01760	Continued From page 96 disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. R1's record lacked evidence of execution of a written contract. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's prescriber orders dated June 10, 2022, included: - acetaminophen (mild pain reliever) 500 milligrams (mg) two capsules by mouth (po) three times per day; - allopurinol (treat gout) 100 mg one tablet po on Monday, Wednesday, Friday, Sunday; 150 mg Tuesday, Thursday, Saturday; - aspirin (heart health) 81 mg one tablet po daily; - azithromycin (antibiotic) 250 mg one tablet po daily; - baclofen (treat muscle spasms) 5 mg one tablet po daily; - buspirone HCL (antianxiety) 30 mg one tablet po twice daily; - calcitriol (supplement) 0.25 micrograms (mcg) one capsule po daily; - Capsicum (supplement) 450 mg one capsule po daily; - Cholecalciferol (supplement) 10 mcg two tablets po daily;	01760		

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01760	Continued From page 97 - cyanocobalamin (supplement) 1000 mcg/milliliter (ml) intramuscular injection once monthly on the 2nd of the month; - gabapentin (relieve nerve pain) 300 mg one capsule po at bedtime; - guaifenesin (treats cough/congestion) 600 mg one tablet po twice daily; - ipratropium-albuterol solution (treat wheezing) 0.5-2.5 (3) mg/ml, 3 ml inhale orally three times per day; - isosorbide mononitrate (prevent chest pain) extended release 30 mg one tablet po daily; - levothyroxine sodium (treat underactive thyroid) 137 mcg one tablet po daily before breakfast; - loratadine (treat allergies) 10 mg one tablet po every other day; - melatonin (sleep aide) 3 mg two tablets po at bedtime; - metoprolol tartrate (treats high blood pressure) 25 mg one tablet po twice daily; - mirtazapine (treats depression) 45 mg one tablet po at bedtime; - NPH (long acting insulin) 100 unit/ml 76 units subcutaneously (SQ) (under the skin) daily; - nystatin (treat fungal skin infection) 100,000 unit/gram topical cream to affected areas of rash twice daily; - Ozempic (treat diabetes) pen injector, 0.5 mg SQ one day per week, on Mondays; - potassium chloride (supplement) 10 milliequivalent (mEq) extended release one tablet po daily with breakfast; - rosuvastatin (lower bad cholesterol) 10 mg one tablet po at bedtime; - torsemide (reduce excess fluid) 40 mg two tablets po daily; and - umeclidinium-vilanterol (treat COPD) 62.5 mcg/spray inhale one puff daily. R1's record included a medication administration	01760		

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01760	Continued From page 98 record (MAR), dated July 2022, which included, "10:00AM med [medication] pass," "2:00PM med pass," "8:00PM med pass," and "10PM med pass," with the time, "Verify # [number of tablets]," and "Nurse." Documentation included initials on each corresponding timeline, under each date, of the person administering the medications. On the "Verify #" line, under each date, indicated the number of tablets that were given from the pill bar, and on the "Nurse" line, under each date included the number of tablets in the pill bar for that specific time, verified by the nurse. The MAR lacked the medication name, dosage, method and route of administration. R1's July 2022 MAR, lacked initials to indicate the medication had been administered for the following: - 2:00 p.m. med pass missing initials on July 28, 2022; - 10:00 p.m. med pass missing initials on July 4, 5, 6, 8, 26, and 29, 2022; - 10:00 a.m. NPH (long-acting insulin) 76 units injection missing initials on July 29, 2022; - 8:00 p.m. fluticasone propionate missing initials 29 of 31 days, with circled initials on July 16, 2022, and July 17, 2022; - Ozempic pen injector missing initials on July 25, 2022; - cyanocobalamin injection missing initials on July 2, 2022; - ipratropium-albuterol solution missing initials at 10:00 a.m. 9 of 31 days, missing initials at 2:00 p.m. 23 of 31 days, and missing initials at 8:00 p.m. 30 of 31 days; - umeclidinium-vilanterol missing initials 13 of 31 days; - nystatin topical cream missing initials at 10:00 a.m. 26 of 31 days, and missing initials at 8:00 p.m. 29 of 31 days.	01760		

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01760	Continued From page 99 R1's July 2022 MAR directed to put initials in the appropriate box when medications were given, circle initials when not given, and to state reason for refusal/omission on the back of the MAR. On August 19, at approximately 2:30 p.m., RN-B verified R1's record lacked documentation of medication administered to include the required content and stated the same process was used for all residents receiving medication administration. RN-B confirmed R1's July 2022 MAR was missing several initials to indicate each medication was administered as ordered, and stated she had not spent much time at this facility so hadn't been able to ensure residents had the required documentation with the required content. TRANSCRIPTION OF PRESCRIBER'S ORDERS R5 R5's diagnosis included diabetes, hyperosmolar hyperglycemic nonketonic syndrome (serious complication of diabetes caused by extremely high blood sugar levels), major depressive disorder, anxiety, mood disorder, muscle weakness, and diabetic neuropathy (damage to nerves by high blood glucose levels). R5's prescriber orders, dated July 25, 2022, included an order for NovoLog FlexPen 100 units/ml, inject 28 units SQ at breakfast, 28 units SQ at noon meal, and 26 units SQ at evening meal. On August 16, 2022, at approximately 11:41 a.m., the surveyor observed while ULP-H assisted R5 with a blood glucose check and assisted R5 to self-administer her insulin. R5's blood sugar result was 201, which ULP-H documented on the MAR. ULP-H assisted R5 by priming the insulin	01760		

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01760	Continued From page 100 pen, and dialed the pen to 28 units as directed on the MAR. ULP-H verbally and visually confirmed with R5 that there were 28 units dialed on the injector pen. R5 used an alcohol wipe to cleanse an area on her abdomen, and self-administered the insulin. Review of R5's August 2022 MAR, indicated the following: - At 8:00 a.m., Insu-Novolog Flexpen 100 units/ml disposable syringe, inject 28 units SQ three times per day, with meals. - At 12:00 p.m., Insu-Novolog Flexpen 100 units/ml disposable syringe, inject 28 units SQ three times per day, with meals. - At 5:00 p.m., Insu-Novolog Flexpen 100 units/ml disposable syringe, inject 26 units SQ three times per day, with meals. On August 18, 2022, at approximately 2:00 p.m., LALD/LPN-A confirmed the transcription of R5's insulin was incorrect and confusing, and stated she would need to have it fixed by the LPN that managed the medication records. The licensee's Medication Management - Administration & Setup policy, dated August 1, 2021, directed documentation of medication administration would be completed immediately after the task has been performed and must include the medication name, dosage, date and time administered, and method and route of administration. The policy also indicated the ULP would document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 101 The licensee's Medications & Treatment Record - Documentation & Refusal policy, dated August 1, 2021, directed the following must be documented in the resident's medication record after providing medication administration: - the date; - the time; - the quantity of dosage; - the method of administration of all prescribed and over-the-counter medications; and - signature and title of the authorized person who provided the assistance and or administration of medications. In addition, the policy indicated if medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. The licensee's Medication & Treatment Orders policy, dated August 1, 2021, directed the RN was responsible for assuring that current, authorized prescriber orders for medications administered by the staff were kept in the resident's record, communicated to the resident or responsible party, educating resident or responsible party on all medication orders, and changes are communicated to the other staff. Also included, the licensed nurse or designee would regularly audit residents' MAR for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 102	01770		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup was completed accurately at the time of set up for one of one resident (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 15, 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided medication management services to the licensee's residents, including weekly medication set up by LALD/LPN-A for each resident, for later administration by unlicensed personnel (ULP). The surveyor requested LALD/LPN-A notify the surveyors when she was preparing to complete medication set up during the survey, so surveyors could observe the process.	01770		

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

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01770	Continued From page 103 R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked evidence of execution of a written contract. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's prescriber orders dated June 10, 2022, included: - acetaminophen (mild pain reliever) 500 milligrams (mg) two capsules by mouth (po) three times per day; - allopurinol (treat gout) 100 mg one tablet po on Monday, Wednesday, Friday, Sunday; 150 mg Tuesday, Thursday, Saturday; - aspirin (heart health) 81 mg one tablet po daily; - azithromycin (antibiotic) 250 mg one tablet po daily; - baclofen (treat muscle spasms) 5 mg one tablet po daily; - buspirone HCL (antianxiety) 30 mg one tablet po twice daily; - calcitriol (supplement) 0.25 micrograms (mcg) one capsule po daily; - Capsicum (supplement) 450 mg one capsule po daily;	01770		

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01770	Continued From page 104 - Cholecalciferol (supplement) 10 mcg two tablets po daily; - cyanocobalamin (supplement) 1000 mcg/milliliter (ml) intramuscular injection once monthly on the 2nd of the month; - gabapentin (relieve nerve pain) 300 mg one capsule po at bedtime; - guaifenesin (treats cough/congestion) 600 mg one tablet po twice daily; - isosorbide mononitrate (prevent chest pain) extended release 30 mg one tablet po daily; - levothyroxine sodium (treat underactive thyroid) 137 mcg one tablet po daily before breakfast; - loratadine (treat allergies) 10 mg one tablet po every other day; - melatonin (sleep aide) 3 mg two tablets po at bedtime; - metoprolol tartrate (treats high blood pressure) 25 mg one tablet po twice daily; - mirtazapine (treats depression) 45 mg one tablet po at bedtime; - potassium chloride (supplement) 10 milliequivalent (mEq) extended release one tablet po daily with breakfast; - rosuvastatin (lower bad cholesterol) 10 mg one tablet po at bedtime; and - torsemide (reduce excess fluid) 40 mg two tablets po daily. On August 19, 2022, at approximately 9:18 a.m., the surveyor again requested to observe LALD/LPN-A during medication set up, as requested upon entrance. LALD/LPN-A stated all residents' medications had been set up for the week, so there would be no opportunity to observe the process. LALD/LPN-A described the process, stating she set the medications up in pill bars, and documented each medication set up, on the medication administration record (MAR), by signing her initial on the day of set up, with a	01770		

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01770	Continued From page 105 line through the number of days that she set up. Review of R1's July 2022 MAR, indicated R1's medications were set up on July 1, 2022, for seven days; July 8, 2022, for seven days; and July 15, 2022, for seven days. The July 2022 MAR lacked documentation for medication set up for July 22, 2022, through July 31, 2022, for all of R1's medications. On August 19, 2022, at approximately 2:30 p.m., RN-B verified R1's July 2022 MAR lacked documentation for medication set up for July 22, 2022, through July 31, 2022, and stated she had not had the opportunity to audit documentation of medication administration or medication set up because she wasn't at this facility very often due to needing to help at the licensee's other facilities. The licensee's Medication Management-Dosage Box Setup policy dated August 1, 2021, indicated when the licensed nurse completed setting up medications into the dosage box, the set-up would be documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	01790		

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01790	Continued From page 106 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	01790		

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01790	Continued From page 107 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 15, 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided medication	01790		

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01790	Continued From page 108 management services to the licensee's residents. On August 18, 2022, at approximately 11:30 a.m., the surveyor observed unlicensed personnel (ULP)-G provide a blood sugar check and assist R2 with insulin dosing. ULP-G returned to the medication storage room and was joined by ULP-E who stated R6's family member was in the facility and requested to take R6's 2:00 p.m. medications to administer to R6 while away on an outing. Although LALD/LPN-A and RN-B were in the facility and available, ULP-G opened the medication book to R6's medication administration record (MAR), retrieved R6's medication pill bar that was labeled for 2:00 p.m., and emptied one tablet into a small clear bag that she pulled out from a container sitting on top of the medication cart. ULP-G wrote R6's name on the bag and rolled it over to close. The surveyor asked ULP-G how she knew how to set up a medication when a resident was leaving the facility. ULP-G stated this was her first time doing it here and she just did what she "knew to do from other jobs" and that no one had shown her how to do it at this facility. ULP-G stated she did not know how to document this and denied having written instructions to follow. LALD/LPN-A entered the medication storage room at this time, with a white envelope, and explained the process to ULP-G, that included writing the name of the resident, the medication, dosage, time to be administered, the RN's name, and then showed ULP-G how to document in the medication book. On August 18, 2022, at approximately 5:12 p.m., LALD/LPN-A verified there was no written procedure for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available.	01790		

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01790	Continued From page 109 The licensee's Medication Management - Planned & Unplanned Time Away policy, dated August 1, 2021, directed medications must be obtained by the pharmacy or set up by a licensed nurse for planned time away. For unplanned time away, when the pharmacy was not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days with the following requirements: - the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and - the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. The policy further directed, for unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: - the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and - the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be	01790		

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01790	Continued From page 110 labeled; - the written information about the medications to be given to the resident or resident's representative; - how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and - how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880		

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01880	Continued From page 111 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and/or document temperatures for one of one medication refrigerator located in the medication storage room. In addition, the facility failed to ensure expired medications were not available for use in one of two medication carts. 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 the entrance conference on August 15, 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided medication management services to the licensee's residents, including storage of medications. MEDICATION REFRIGERATOR On August 18, 2022, at approximately 9:45 a.m., the surveyor observed the small medication refrigerator in the medication storage room with unlicensed personnel (ULP)-G. The medication refrigerator contained several unopened insulin pens; however, there was no thermometer in the	01880		

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01880	Continued From page 112 refrigerator. ULP-G stated she thought there was a thermometer for the refrigerator, but it had been cleaned last Friday and she didn't know where the thermometer was. When the surveyor asked if refrigerator temperatures were taken and recorded, ULP-G stated, "I don't know." On August 18, 2022, at approximately 11:00 a.m., director of maintenance (DM)-C stated he was not aware that there was no thermometer in the medication refrigerator and stated he had now placed one in there. DM-C stated he did not know if there was a temperature log kept to monitor the temperature. On August 18, 2022, at approximately 1:02 p.m., the surveyor conducted a second observation of the medication refrigerator with ULP-E. The medication refrigerator had a thermometer, with current temperature of 35 degrees Fahrenheit (F). The refrigerator contents included the following: - 12 NovoLog (short acting insulin) FlexPens; - 1 Novolin N (short acting insulin) Flexpen; - 10 Trulicity (used weekly to treat diabetes) injectable pens; - 10 Lantus Solostar (long acting insulin) pens; - 1 Ozempic (used weekly to treat diabetes) 2 milligram injectable pen; and - 8 Humulin N (short acting insulin) pens. The manufacturer's instructions for NovoLog FlexPen, dated November 2021, indicated unused insulin should be stored in a refrigerator at 36 to 46 degrees F to maintain potency. Do not use NovoLog Flex if it has been frozen. The manufacturer's instructions for Novolin N Flexpen, dated 2022, indicated store unopened containers in the refrigerator at 36 to 46 degrees	01880		

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01880	Continued From page 113 F. Do not freeze. The manufacturer's instructions for Trulicity injectable pen, dated July 2022, indicated pen should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze the pen. If the pen has been frozen, throw it away and use a new pen. The manufacturer's instructions for Lantus Solostar indicated unopened pens should be refrigerated between 36 to 46 degrees F, and should not be allowed to freeze. Discard if it has been frozen. The manufacturer's instructions for Ozempic pens, dated June 2022, indicated unused pens should be stored in the refrigerator between 36 to 46 degrees F. Do not use if it has been frozen. The manufacturer's instructions for Humulin N pens, dated June 2020, indicated store unused Pens in the refrigerator at 36 to 46 degrees F. Do not freeze and do not use if it has been frozen. EXPIRED MEDICATIONS On August 18, 2022, at approximately 1:02 p.m., in the presence of ULP-E, the surveyor observed the licensee's two medication carts in the medication storage room. The larger cart's top drawer, labeled "stock meds [medications that can be used by multiple residents when needed]," contained the following expired medications: - one bottle of Vicks Vapo-Rub (mentholated topical ointment intended for use on the chest, back and throat for cough suppression), expired December 2020; - one bottle of Vicks Vapo-Rub, expired August 2018; - one bottle of Tums (to treat indigestion), expired	01880		

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01880	Continued From page 114 March 2022; and - one diclofenac 1% topical gel (used to relieve pain in joints), expired March 2022. On August 19, 2022, at approximately 3:05 p.m., RN-B confirmed the medication refrigerator temperature should be monitored to ensure safe temperatures for the stored medication, and verified medication carts should not contain expired medications that were ready for use. RN-B stated it was frustrating because she was "rarely at this house, so I don't know." The licensee's Medication Storage policy, dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 prescription medications were kept in the original container bearing the original prescription label, and	01890		

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01890	Continued From page 115 included the expiration date of a time-dated drug, for one of one resident (R5). 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 August 16, 2022, at approximately 11:41 a.m., the surveyor observed unlicensed personnel (ULP)-H assist R5 with a blood sugar check and then self-administration of her insulin. ULP-H documented the blood sugar results on the medication administration record (MAR), primed the insulin pen, and then dialed the insulin pen to the correct dosage as directed on the MAR. ULP-H verbally and visually confirmed with R5 that the pen was dialed to 28 units. R5 cleansed an area on her abdomen with an alcohol wipe and self-administered the insulin. On August 16, 2022, at approximately 11:50 a.m., the surveyor observed R5's insulin pen was in the medication cart, in R5's storage area; however, lacked labeling to confirm it was R5's insulin pen, and nowhere on the pen was there an indication of the date the insulin pen was opened or the beyond use date. On August 16, 2022, at approximately 11:55 a.m., the surveyor asked ULP-H how she could confirm the insulin pen belonged to R5 when it wasn't labeled with her name. ULP-H stated the insulin	01890		

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

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01890	Continued From page 116 pen was in R5's drawer and R5's picture was in the drawer. At approximately 12:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A entered the medication room, and stated if the insulin pens weren't in the correct resident's drawer, the staff could look at the stock number on the pen if there was a question about who's pen it was, and compare it to the labeled box in the medication refrigerator; however, added the likelihood of staff doing so was "unlikely." LALD-LPN-A indicated she would provide a means for staff to label insulin pens with the proper information, including the date opened, and would educate the staff to ensure it was completed. The licensee's Medications-Prescription Drugs & Prohibition policy, dated August 1, 2021, directed the prescription drug 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.	01910		

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01910	Continued From page 117 (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication, to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked documentation of medication disposition upon R4's discharge from the facility.	01910		

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01910	Continued From page 118 R4's diagnoses included dementia, major neurocognitive disorder with behavioral disturbance, congestive heart failure, and malnutrition. R4 began receiving services on April 11, 2022, and was discharged on June 3, 2022. R4's Service Plan form, dated April 11, 2022, indicated R4 received services including assistance with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, bathing, medication administration, hands-on assistance with transfers and mobility, laundry and housekeeping. R4's progress notes, dated June 3, 2022, with no time notation, indicated R4 was taken to the emergency department due to being "out of control." R4's progress note on June 4, 2022, indicated R4's family member called the facility asking about R4 being able to return to the facility. Registered nurse (RN)-B documented she suggested R4 "would probably do well," at a facility that provided "24/7 nurse on site." There were no further progress notes; however, R4 did not return to the facility. In addition, there was no mention of the disposition of R4's medications. R4's record lacked evidence of documentation of R4's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On August 18, 2022, at approximately 7:28 a.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A verified a disposition of	01910		

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01910	Continued From page 119 R4's medications was not completed. The licensee's Medication Disposal policy, dated August 1, 2021, indicated current unused medications managed by the licensee would be returned to the pharmacy for credit, or given to the resident or the resident's representative when the resident's medications are no longer managed by the facility. The policy also included, upon disposition, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. The policy also indicated a copy of the destruction record would be kept on file at the facility for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 120 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (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) 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). Findings include: During the entrance conference on August 15,	01940		

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01940	Continued From page 121 2022, at approximately 4:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and registered nurse (RN)-B stated the licensee provided treatment and therapy management services to the licensee's residents, including oxygen management, compression stockings, modified diets, wound care, and blood glucose monitoring. R1 R1 was admitted to the licensee for services, from another facility owned by the licensee, on June 10, 2022. R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked execution of a written contract. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's prescriber orders, dated July 26, 2022, included blood sugar diagnostic strips to be used twice daily. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's Uniform Assessment Tool included a section titled "Treatments," and listed oxygen, blood glucose, and inhalers; however, the frequency and	01940		

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01940	Continued From page 122 assistance needed columns were blank. R1's Medication Administration Record (MAR), dated August 1, 2022, through August 19, 2022, indicated "Check blood sugar 2 x/day [twice daily] before meals for diabetes mellitus. Notify [LALD/LPN-A] to call CNP [certified nurse practitioner] of blood sugar is less than 100 or over 220 fasting." The MAR included blood glucose monitoring documentation, indicating blood glucose checks had been completed twice daily (at 10:00 a.m., per R1's preference for late breakfast) and at 5:00 p.m., with results ranging from 81 to 234 milligrams (mg)/deciliter (dl). R1's record lacked a treatment management plan to include the following required content: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R2 R2 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022. R2's diagnoses included diabetes, cerebral infarction (stroke) with left sided weakness, dysphagia (difficulty swallowing), acute myocardial infarction (heart attack), dementia, bipolar disease, weakness, and osteoarthritis. R2's record lacked execution of a written contract. R2's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee.	01940		

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01940	Continued From page 123 R2's prescriber orders, dated August 4, 2022, included blood glucose checks four times daily. R2's MAR, dated August 1, 2022, through August 19, 2022, directed, "Blood sugar checks (One touch Verio Flex/Blood Glucose Meter). Test as directed for diabetes control. 8am, 12 noon, 5pm, HS." The MAR included blood glucose monitoring documentation, indicating blood glucose checks had been completed three times daily, at 7:30 a.m., 11:30 a.m., and 4:30 a.m., with results ranging from 89 to 203 mg/dl. R2's record lacked a treatment management plan to include the following required content: - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - verification that all treatment and therapy was administered as prescribed. On August 19, 2022, at approximately 2:30 p.m., RN-B verified R1 and R2's treatment management plans lacked the above required content. The licensee's Treatment & Therapy Management Plan policy, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - A statement of the type of services that will be provided; - Documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 124 - Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; - Any resident-specific requirements relating to documentation of treatment and therapy received; - Verification that all treatment and therapy was administered as prescribed; and - Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	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	01950		

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01950	Continued From page 125 in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure instructions were specified in writing for each resident and were documented in the resident's record for two of two residents (R5, R2) observed during blood glucose monitoring. 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: R5 R5's diagnosis included diabetes, hyperosmolar hyperglycemic nonketonic syndrome (serious complication of diabetes caused by extremely high blood sugar levels), major depressive disorder, anxiety, mood disorder, muscle weakness, and diabetic neuropathy (damage to nerves by high blood glucose levels). On August 16, 2022, at approximately 11:41 a.m., the surveyor observed unlicensed personnel (ULP)-H assist R5 with a blood glucose check and self-administration of insulin. ULP-H noted R5's blood sugar was 201 milligrams (mg)/deciliter (dL), and assisted R5 to prime the insulin pen and verified the dosage R5 dialed on	01950		

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01950	Continued From page 126 the insulin pen. R5 used an alcohol wipe to clean an area on her abdomen and self-administered the insulin. R5's Medication Administration Record (MAR), dated August 1, 2022, through August 16, 2022, directed for blood glucose checks to be completed four times a day (7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m.) before meals and at bedtime. R5's blood glucose monitoring documentation, indicated blood glucose checks had been completed four times daily with staff having documented results ranging from 71 to 305 mg/dL. R5's MAR directed, "If low blood sugar or symptomatic contact nurse ASAP [as soon as possible]. Give OJ [orange juice] with sugar if instructed & recheck blood sugar in 15 minutes." During an interview on August 16, 2022, at approximately 11:48 a.m., the surveyor asked ULP-H what she would consider a low blood sugar that would cause her to contact the nurse. ULP-H stated R5 was usually hyperglycemic (high blood sugar) but she would "watch for symptoms," which included "[R5] shakes." ULP-H confirmed R5 normally had a tremor, but stated, "Her hands shake more," when blood sugars were low. ULP-H indicated licensed assisted living director (LALD)/licensed practical nurse (LPN)-A had trained her how to conduct blood sugar checks and stated the registered nurse (RN) had watched her. R5's record lacked documentation of specific, written instructions, and lacked evidence the instructions were communicated with the ULP about the individual needs of the resident. ULP-H's employee record lacked evidence of	01950		

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01950	Continued From page 127 having been instructed in the proper methods with respect to each resident, and lacked evidence ULP-H had demonstrated the ability to competently follow the procedure to the RN. R2 R2's diagnoses included diabetes, cerebral infarction (stroke) with left sided weakness, dysphagia (difficulty swallowing), acute myocardial infarction (heart attack), dementia, bipolar disease, weakness, and osteoarthritis. R2's record lacked execution of a written contract. R2's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R2's prescriber orders, dated August 4, 2022, included blood glucose checks four times daily. On August 18, 2022, at approximately 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-G complete R2's blood sugar check in R2's room. ULP-G returned to the medication storage room and recorded R2's blood sugar result of 137 on R2's MAR. R2's MAR, dated August 1, 2022, through August 19, 2022, directed to check blood glucose (sugar) at 7:30 a.m., 11:30 a.m., 4:30 p.m., and at HS (bedtime). The MAR included directions to put initials in appropriate box when the task was completed, circle initials when not completed, and state reason for refusal/omission on the back of the form. The MAR indicated R2 was hospitalized on August 1, 2022, after the 7:30 a.m. blood glucose check, through the 11:30 a.m. blood glucose check on August 4, 2022. R2's MAR	01950		

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01950	Continued From page 128 indicated blood glucose checks had been completed every day at 7:30 a.m., as ordered, as evidenced by initials in each box of the staff completing the task; however, lacked results of the blood glucose check on August 11, 2022. The 11:30 a.m. blood glucose check lacked initials to indicate completion on August 9, 2022, and August 17, 2022, and the 4:30 p.m. blood glucose checks had initials documented with results, every day. The HS blood glucose checks lacked initials to indicate completion from August 4, 2022, through August 18, 2022. The back page of R2's MAR was blank, lacking documentation as to the reason the blood glucose checks were not completed and any follow up procedures that were provided to meet the resident's needs. On August 18, 2022, at 12:08 p.m., the surveyor asked ULP-G about the missing documentation on R2's MAR for the HS blood sugar check. ULP-G stated she didn't know what "HS" meant and stated, "Maybe hospital?" ULP-G stated she occasionally worked the evening shift, but was not aware that "HS" meant hours of sleep or bedtime. ULP-G stated, "Why would it not be written for 8:00 p.m. like the other residents?" The surveyor asked ULP-G what direction she was given as to when to contact the nurse regarding concerns with blood glucose monitoring. ULP-G stated, "when [R2] is very low or very high, or when she has symptoms." When the surveyor asked what symptoms R2 displayed with high or low blood sugars or what specifically to watch for, ULP-G stated, "I'm not quite sure." R2's record lacked documentation of specific, written instructions and evidence the instructions were communicated with the ULP about the individual needs of the resident.	01950		

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 129 ULP-G's employee record lacked evidence of having been instructed in the proper methods with respect to each resident and lacked evidence ULP-G had demonstrated the ability to competently follow the procedure to the RN. On August 18, 2022, at approximately 3:00 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A stated the directions for the ULP "certainly need to be clearer than that." On August 19, 2022, at approximately 2:30 p.m., RN-B verified R5 and R2's records lacked specific, written instructions for the procedures, including when the registered nurse should be notified. In addition, RN-B stated she had not been able to provide any training to the licensee's ULPs or to ensure the ULPs had demonstrated the ability to competently follow the procedures, and had not communicated the individual needs of the resident with the ULPs, because she had been busy at another of the licensee's facilities and hadn't been able to spend much time at this facility. The licensee's Medication & Treatment - Administration & Delegation policy, dated August 1. 2021, indicated when administration of treatment/therapy was delegated or assigned to ULP, the licensee would ensure that the RN had instructed the ULP in the proper methods with respect to each resident to perform treatment/therapy and the ULP has demonstrated the ability to competently follow the procedures, and the RN had specified in writing, specific instructions for each resident and documented those instructions in the resident's record. In addition, the RN would have communicated with the ULP about the individual needs of the resident.	01950		

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01950	Continued From page 130 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	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, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for two of two residents (R1, R2) receiving blood glucose monitoring and wound care. 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 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	01960		

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01960	Continued From page 131 occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked execution of a written contract. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's prescriber orders, dated June 9, 2022, included blood sugar diagnostic strips to be used twice daily and wound care including acetic acid soaks to breast, abdominal, and groin folds topically three times per day. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's Uniform Assessment Tool included a section titled "Treatments," and listed oxygen, blood glucose, and inhalers; however, the frequency and assistance needed columns were blank, and wound care was not listed. R1's medication administration record (MAR), dated July 1, 2022, through July 31, 2022, directed to check blood sugar twice daily before	01960		

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01960	Continued From page 132 meals, at 10:00 a.m., and at 5:00 p.m., and to notify licensed assisted living director (LALD)/licensed practical nurse (LPN)-A to call certified nurse practitioner (CNP) if fasting blood sugar was less than 100 or over 220 milligrams (mg)/deciliter (dl), and to notify provider if blood glucose was consistently less than 90 or if R1 complained of hypoglycemia symptoms (shaky, dizzy, sweating, lightheaded, lethargic, etc.). The MAR included directions to put initials in appropriate box when the task was completed, circle initials when not completed, and state reason for refusal/omission on the back of the form. R1's MAR indicated blood glucose checks had been completed every day at 10:00 a.m., as ordered, as evidenced by initials in each box of the staff completing the task; however, the following dates lacked initials for the 5:00 p.m. blood sugar check and the back page of the MAR lacked documentation as to the reason the blood glucose checks were not completed and any follow up procedures that were provided to meet the resident's needs: -July 1, 2022; -July 2, 2022; -July 5, 2022; -July 6, 2022; -July 8, 2022; -July 9, 2022; -July 10, 2022; -July 11, 2022; and -July 30, 2022. R1's MAR, dated July 1, 2022, through July 31, 2022, also directed wound care with acetic acid soaks to breast, abdominal, and groin folds topically three times daily, at 10:00 a.m., 2:00 p.m., and 8:00 p.m. The MAR lacked initials for all three times on July 1, 8, 9, 10, 11, 12, 13, 14, 23, 24, 2022. The MAR indicated the wound care	01960		

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01960	Continued From page 133 was completed at 10:00 a.m., on July 16, 17, 18, 19, 21, 22, 25, 26, 27, 28, 29, 30, and 31, 2022, but were blank the rest of the day. In addition, the MAR had initials that were circled at 10:00 a.m., and 2:00 p.m., on July 2, 3, 4, and 15, 2022, and at 8:00 p.m., on July 5, 6, and 7, 2022; however, the back page of the MAR lacked documentation as to the reason the wound care was not completed and any follow up procedures that were provided to meet the resident's needs. R2 R2's diagnoses included diabetes, cerebral infarction (stroke) with left sided weakness, dysphagia (difficulty swallowing), acute myocardial infarction (heart attack), dementia, bipolar disease, weakness, and osteoarthritis. R2's record lacked execution of a written contract. R2's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R2's prescriber orders, dated August 4, 2022, included blood glucose checks four times daily. On August 18, 2022, at approximately 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-G complete R2's blood sugar check in R2's room. ULP-G returned to the medication storage room and recorded R2's blood sugar result of 137 on R2's MAR. R2's MAR, dated August 1, 2022, through August 19, 2022, directed to check blood glucose (sugar) at 7:30 a.m., 11:30 a.m., 4:30 p.m., and at HS (bedtime). The MAR included directions to put initials in appropriate box when the task was	01960		

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01960	Continued From page 134 completed, circle initials when not completed, and state reason for refusal/omission on the back of the form. The MAR indicated R2 was hospitalized on August 1, 2022, after the 7:30 a.m. blood glucose check, through the 11:30 a.m. blood glucose check on August 4, 2022. R2's MAR indicated blood glucose checks had been completed every day at 7:30 a.m., as ordered, as evidenced by initials in each box of the staff completing the task; however, lacked results of the blood glucose check on August 11, 2022. The 11:30 a.m. blood glucose check lacked initials to indicate completion on August 9, 2022, and August 17, 2022, and the 4:30 p.m. blood glucose checks had initials documented with results, every day. The HS blood glucose checks lacked initials to indicate completion from August 4, 2022, through August 18, 2022. The back page of R2's MAR was blank, and lacked documentation as to the reason the blood glucose checks were not completed and any follow up procedures that were provided to meet the resident's needs. On August 18, 2022, at 12:08 p.m., the surveyor asked ULP-G about the missing documentation on R2's MAR for the HS blood sugar check. ULP-G stated she didn't know what "HS" meant and stated, "Maybe hospital?" ULP-G stated she occasionally worked the evening shift, but was not aware that "HS" meant hours of sleep or bedtime. ULP-G stated, "Why would it not be written for 8:00 p.m. like the other residents?" On August 19, 2022, at approximately 2:40 p.m., RN-B verified R1 and R2's records lacked the above required content. The licensee's Medication & Treatment Record-Documentation & Refusal, dated August 1, 2021, indicated the licensee would create and	01960		

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01960	Continued From page 135 maintain a correct and accurate treatment/therapy record for each resident receiving treatments and therapies. The policy directed documentation in the resident's record after providing the treatment, including the date, time, method of administration, and a signature and title of the authorized staff who provided the treatment/therapy. In addition, the policy indicated, if treatment/therapy assistance or administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02240 SS=B	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints,	02240		

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02240	Continued From page 136 Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for two of two residents (R1, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number	02240		

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02240	Continued From page 137 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 was admitted to the licensee for services, from another facility owned by the licensee, on June 10, 2022. R1's diagnoses included major depressive disorder, type 2 diabetes, morbid obesity, anxiety, chronic obstructive pulmonary disease, and chronic kidney disease. R1's record lacked execution of a written contract. R1's Uniform Assessment Tool, dated June 10, 2022, after hospital return and admission to the licensee, indicated R1 required full assistance with housekeeping and laundry, was independent with toileting, bed mobility, eating after set-up, and making transportation arrangements, and required assistance with bathing. R1's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R1's record lacked written acknowledgement that she received the current Minnesota Bill of Rights for Assisted Living Residents, as required. R3 R3 was admitted to the licensee for services, from another facility owned by the licensee, on June 14, 2022.	02240		

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02240	Continued From page 138 R3's diagnoses included paranoid schizophrenia, bipolar disorder, abnormal gait, and diabetes. R3's record lacked execution of a written contract. R3's Uniform Assessment Tool, dated April 10, 2022, and completed by the previous facility, indicated R3 was resistive to cares, was verbally aggressive, defiant, and displayed inappropriate sexual behavior. Also included, R3 required full assistance with housekeeping and laundry, incontinence, bathing, mobility, transfers, eating, and making transportation arrangements. Further, a handwritten note on July 6, 2022, indicated R3 had moved from the "Plummer House" to this licensee and had adjusted well to the move. R3's record lacked evidence of a service plan documenting agreement on the services to be provided by the licensee. R3's record lacked written acknowledgement that she received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On August 17, 2022, at approximately 1:56 p.m., licensed assisted living director (LALD)/licensed practical nurse (LPN)-A and RN-B stated R3, and three other residents, had moved to the facility from another facility owned by the licensee that was closing, on June 14, 2022, and R1 had moved to the facility from a third facility owned by the licensee, on June 10, 2022. LALD/LPN-A stated she was not aware that these residents required all new paperwork upon admission to the facility, including written acknowledgement of receipt of the current Assisted Living Bill of	02240		

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02240	Continued From page 139 Rights. The licensee's Bill of Rights policy, dated August 1, 2021, indicated the licensee would provide the resident or the resident's representative with a written copy of the Assisted Living Bill of Rights before the date that services were first initiated. In addition, the policy included the licensee must obtain written acknowledgement of the resident's receipt of the BOR or shall document why an acknowledgement could not be obtained, and would be retained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with an assistive device and one of two residents (R3) with a hospital bed with bedrails. 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,	02310	On August 17, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a widespread level 3 violation.	

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02310	Continued From page 140 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). This practice resulted in an immediate order for correction on August 17, 2022. The findings include: ASSISTIVE DEVICE R2 On August 16, 2022, at approximately 1:07 p.m., the surveyor observed RN-B measure R2's assistive device on the right side of her bed. The device was a single, metal, square-shaped device, with black foam across the top, and had two metal poles with rubber stoppers that extended to the floor. The device had metal bars, in the shape of a large square, that slid between the mattress and the bed frame. The assistive device had an opening that measured 14 inches in width. The space between the mattress and the device measured 1.5 inches. R2 stated she used the assistive device to get in and out of bed. R2's diagnoses included bipolar disorder, depression without psychosis, obstructive sleep apnea, diabetes with neuropathy (damage to peripheral nerves), obesity, nicotine dependence, failure to thrive, pain of left toe and self-care deficit. R2's Weatherstone Senior Living LLC Service Plan (other facility owned by same licensee) dated July 10, 2019, indicated R3 received services which included medication management,	02310		

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WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

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02310	Continued From page 141 treatments (not defined), bathing, hygiene, dressing, grooming, toileting, laundry, housekeeping, meals, positioning and transfers, and exercise reminders. R2's Restraints: Side Rail Utilization Assessment, dated July 26, 2022, indicated R2 and her legal representative requested the bedrails, and indicated R2 had a fall history and a history of falls from the bed. The assessment indicated R2 was independent getting in and out of bed, used a walker, was scheduled for bathroom assistance every two hours at night, and had decreased safety awareness due to confusion or judgement problems. R2's record included Healthcraft manufacturer's installation instructions for the assistive device and licensed assisted living director (LALD)/licensed practical nurse (LPN)-A indicated in a handwritten note on the instructions on July 22, 2022, there were no recalls for the device. R2's Risk Agreement-Bed Rails, dated July 26, 2022, indicated R2 and her representative had chosen to purchase and/or utilize bed rails "To assist getting in or out of bed," and "To assist with repositioning in bed." The agreement included measurements of the device, noting only that the width of the opening was 13 inches. The agreement lacked a description of the resident's ability to use the device safely and lacked documentation of the risk for entrapment or the interventions to mitigate the safety risk. The agreement included, "After education about the high risk of entrapment resulting in injuries and/or death, and the recommended dimensional guidance in the 2006 FDA guidelines, the client and/or client representative(s) have chosen to implement bed rails." Also included, "The	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30801	A. BUILDING: _____ B. WING _____	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS & WATERS SENIOR LIVING	707 UPPER MEADOW LANE NW ROCHESTER, MN 55901

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02310	Continued From page 142 undersigned Client and/or Responsible Party understands and accepts responsibility for the possible outcomes of the agreed-upon course of action." The Risk Agreement was signed by RN-B on July 26, 2022; however, lacked a signature from R2 or her responsible party, to indicate written acknowledgement of the risks and benefits of using bed rails. On August 17, 2022, at approximately 8:42 a.m., the surveyors and RN-B entered R2's room to observe the bedrails. R2 was in her bed, lying on her back without covers diagonally with her feet hanging over the end of the bed. RN-B stated, "This is how she sleeps." The surveyor remeasured the opening of the assistive device, while RN-B observed, noting the opening inside the device was 14 inches wide and 10 inches in length. On August 17, 2022, at approximately 8:58 a.m., RN-B and LALD/LPN-A were interviewed. LALD/LPN-A stated she was present when the device was installed and stated the device was secured to the bed frame with a strap and the bar that the resident grasps was magnetic and as soon as pressure was applied, the bar would swing out to assist the resident to stand. RN-B and LALD/LPN-A verified R2's assistive device had an opening that was large enough to pose a safety risk. RN-B stated all she did was measure the bedrails in the facility and document them; however, did not assess the residents' ability to use the device safely or determine interventions to mitigate the safety risk of the device. LALD/LPN-A stated she discussed the risks and benefits with each resident and their representatives but verified there was no signature or documentation acknowledging their understanding.	02310		

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	30801	A. BUILDING: _____ B. WING _____	08/22/2022

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02310	Continued From page 143 HOSPITAL BED R3 On August 16, 2022, at approximately 12:58 p.m., the surveyor observed registered nurse (RN)-B measure R3's bilateral bedrails affixed to the hospital bed. The right bedrail was in the raised position, and the left bedrail was in the down position. RN-B stated she had lowered the left bedrail this morning when she made R3's bed; however, R3's bedrails were always in the raised position when R3 was in the bed. The nine openings between the bars for zone 1 varied in size, with the largest opening measuring 3.5 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. R3's diagnoses included paranoid schizophrenia (mental health illness including hallucinations and delusions), bipolar disorder (mental illness with mood swings), diabetes and abnormal gait. R3's Shalom Home LLC Service Plan (other facility owned by same licensee), dated August 1, 2020, indicated R3 received services which included medication management, bathing assistance, dressing, grooming, toileting, meals, mobility and transfer assistance, housekeeping and laundry. R3's record included a Restraints: Side Rail Utilization Assessment, dated July 26, 2022, which indicated R3's legal representative requested the bedrails, R3 had no fall history, was non-ambulatory and required a mechanical lift for transfers. The assessment indicated R3 had frequent toileting checks during the night, with incontinence care every two hours.	02310		

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02310	Continued From page 144 R3's Risk Agreement-Bed Rails, dated July 26, 2022, indicated R3 and her representative had chosen to purchase and/or utilize bed rails "To prevent falls from bed," and "To assist with repositioning in bed." The agreement included measurements of the zones, consistent with the 2006 Food and Drug Administration (FDA) guidelines, and included, "After education about the high risk of entrapment resulting in injuries and/or death, and the recommended dimensional guidance in the 2006 FDA guidelines, the client and/or client representative(s) have chosen to implement bed rails." Also included, "The undersigned Client and/or Responsible Party understands and accepts responsibility for the possible outcomes of the agreed-upon course of action." The Risk Agreement was signed by RN-B on July 26, 2022; however, lacked a signature from R3 or her responsible party, to indicate written acknowledgement of the risks and benefits of using bed rails. On August 16, 2022, at approximately 10:15 a.m., LALD/LPN-A, stated she discussed the risks and benefits of bed rail usage with R3 and her representative; however, verified the risk agreement lacked a signature to acknowledge they had been educated about the risks. The licensee's Side Rails policy, dated August 1, 2021, indicated the RN must conduct an assessment to identify the intended purpose of the bedrails and the risks regarding the use of the bed rail. Also included, staff would determine if the bed rail was considered to be safe, meeting all of the requirements, including the bedrail was used consistent with manufacturer's directions, the bed rails were installed securely and maintained in good operating condition, and the bed rail design was consistent with the FDA's	02310		

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02310	Continued From page 145 2006 recommended dimensional measurements to reduce entrapment. Further, the policy indicated the resident and representative shall be informed of the risks and benefits regarding the use of bedrails and this would be documented in the resident's record. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".	02310		

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02310	Continued From page 146 The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/16/22*
Time: 12:05:01
Report: 7920221153

Food and Beverage Establishment Inspection Report

Location:
Willows & Waters Senior Living
707 Upper Meadow Lane Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0037900
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079517887
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

One refrigerator was out of temperature. Food inside was not TCS or minimal risk. Minimal risk food was thrown away non-TCS food was moved to another locaion.

Corrected on Site

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Get the training done and get the state food protection manager certificate for this location.

Comply By: 09/16/22

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 154 Degrees Fahrenheit - Location: Burger
Violation Issued: No

Process/Item: Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Eggs, milk, fruit,, vegetables
Violation Issued: No

Process/Item: Bottom Freezer
Temperature: 1 Degrees Fahrenheit - Location: Ice cream treats
Violation Issued: No

Process/Item: Top Freezer
Temperature: 11 Degrees Fahrenheit - Location: Vegetables,
Violation Issued: No

Process/Item: Refrigerator
Temperature: 45 Degrees Fahrenheit - Location: Unopened sauerkraut, watermelon, bread, sour cream
Violation Issued: Yes

Process/Item: Chest freezer
Temperature: 0 Degrees Fahrenheit - Location: Breakfast sandwiches, tator tots
Violation Issued: No

Process/Item: Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Soda, eggs, cheese
Violation Issued: No

Process/Item: Refrigerator
Temperature: 37 Degrees Fahrenheit - Location: Soda
Violation Issued: No

Process/Item: Refrigerator
Temperature: 37 Degrees Fahrenheit - Location: Berries, biscuts
Violation Issued: No

Process/Item: freezer
Temperature: 0 Degrees Fahrenheit - Location:
Violation Issued: No

Process/Item: Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Fruit
Violation Issued: No

Process/Item: freezer
Temperature: 0 Degrees Fahrenheit - Location: Fries
Violation Issued: No

Process/Item: Refrigerator
Temperature: 38 Degrees Fahrenheit - Location: Pickles, fruit
Violation Issued: No

Process/Item: Chest freezer
Temperature: 0 Degrees Fahrenheit - Location: Treats
Violation Issued: No

Process/Item: Refrigerator
Temperature: 33 Degrees Fahrenheit - Location: Soda, syrup,
Violation Issued: No

Type: Full
Date: *08/16/22*
Time: 12:05:01
Report: 7920221153
Willows & Waters Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: freezer
Temperature: 4 Degrees Fahrenheit - Location: Breakfast foods
Violation Issued: No

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

I acknowledge receipt of the inspection report number 7920221153 of 08/16/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us