Electronically Delivered

November 17, 2021

Administrator
Brookdale Mankato
100 Teton Lane
Mankato, MN 56001

RE: Project Number(s) SL30560001

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 14, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

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

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You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30560	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MANKATO	100 TETON LANE MANKATO, MN 56001

(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 ORDERS In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders have 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: SL30560015 On October 12, 2021 through October 14, 2021, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were 17 residents that were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, 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 (R2, R1) 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 of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include:	0 430		

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0 430	Continued From page 2 R2 On October 13, 2021, at approximately 7:53 a.m. unlicensed personnel (ULP)-A was observed to administer oral medications to R2. R2's Service Plan dated October 11, 2021, indicated services included medication administration, chronic conditions management, bathing or showering and service coordination. R2's record lacked 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. R1 On October 13, 2021, at approximately 8:24 a.m. ULP-A was observed to administer oral medications to R1. R1's Service Plan dated July 12, 2021, indicated services included medication administration, dressing/grooming, chronic condition management, respiratory equipment, nutrition, showers, bathroom assistance, escort/mobility, two-person transfer, cognitive/psychosocial, behavior management, skin care, and service coordination. R1's record lacked 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. On October 13, 2021, at approximately 1:47 p.m.	0 430		

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0 430	Continued From page 3 licensed assisted living director (LALD)-A and registered nurse (RN)-A confirmed R2 and R1 had not received a written checklist listing all services permitted under the facility's license, and the services not provided under the facility's license. The licensee lacked a policy regarding the uniform checklist disclosure of services. 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, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 480		

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0 480	Continued From page 4 review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 17 current residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 12, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect all the 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. Upon entrance to the licensee's establishment on October 12, 2021, at approximately 9:30 a.m. unlicensed personnel (ULP)-A and ULP-B were observed wearing a surgical face mask, and no eye protection. On October 12, 2021, at approximately 10:13 a.m. ULP-A was observed to interact with R1. ULP-A wore a medical-grade facemask; however, no eye protection was worn.	0 510		

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0 510	Continued From page 6 On October 12, 2021, at approximately 3:06 p.m. ULP-A, ULP-B and one unidentified staff were observed to be sitting at a table in the common area, wearing a surgical face mask, but no eye protection. On October 12, 2021, at approximately 3:24 p.m. a box of goggles was observed at the employee entrance for employee use. A sign on the wall by the box read, "Sanitize hands, Face mask, Eye protection, Screen." Also observed on the same wall was the "COVID-19 Personnel Protective Equipment [PPE] Grid for Congregate Care Settings." On October 12, 2021, at approximately 4:19 p.m. registered nurse (RN)-A stated employees should be wearing eye protection performing direct contact with residents. RN-A was not aware a medical grade facemask and a face shield or goggles were required to be worn when around and/or providing cares to residents. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. The Minnesota Department of Health COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 in your facility staff actions include the "use of eye protection (e.g., face shield, goggles) during all resident care encounters to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff	0 510		

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0 510	Continued From page 7 are in a resident care area. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work." The licensee's Face mask and face shield use during COVID-19 pandemic policy revised July 2021, did not address wearing eye protection. A face shield was to be worn if a face mask cannot be worn due to a medical necessity, medical condition or disability as defined in the Americans with Disability Act or due to a religious belief. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: 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.	0 550		

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0 550	Continued From page 8 This had the potential to affect the 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) 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 the residents). The findings include: The licensee lacked a posting of the grievance procedure to include any information for reporting suspected maltreatment to Minnesota Adult Abuse Reporting Center (MAARC). On October 12, 2021, during the facility tour at approximately 11:20 a.m. the surveyor observed a bulletin board in the hallway near the licensee's salon with the grievance procedure hanging on it. The attached procedure did not include information for reporting suspected maltreatment to the MAARC. On October 12, 2021, at approximately 12:56 p.m. licensed assisted living director (LALD)-A confirmed the required content noted above was not currently posted as required. The licensee's Grievance Procedure-Resident policy revised dated August 2021, did not address information on how to report maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION:	0 550		

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0 550	Continued From page 9 Twenty-One (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test and TB training for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 10 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 12, 2021, at approximately 10:10 a.m. with licensed assisted living director (LALD)-A and RN-A, a request was made to review the facility TB risk assessment. TB risk assessment was completed October 12, 2021, after the surveyor's request. RN-A confirmed the TB risk assessment was filled out after the request was made. RN-A had a start date of July 22, 2019. RN-A's employee record did not contain the following: - documentation of a completed health history and symptom screening; - completion of a two-step TST or other evidence of TB screening such as a blood test; and - TB training On October 14, 2021, at approximately 10:52 a.m. RN-A confirmed the required TB history and symptom screening, two-step TST or blood test and TB training was not completed as required. The licensee's Tuberculosis Exposure Control Plan policy revised August 2021, indicated the Facility TB Risk Assessment will be completed every two years for low-risk facilities. Baseline TB screening is required at the time of hire for	0 660		

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0 660	Continued From page 11 current symptoms of TB, assessing TB history and testing for active or latent mycobacterium tuberculosis by administering either a two-step skin test (TST) or a single TB blood test (IGRA.) The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. 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;	0 680		

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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
0 680	Continued From page 12 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a written emergency disaster plan with all the required content outlined in Appendix Z. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 12, 2021, at approximately 10:30 a.m. during the entrance conference, the facility emergency planning information was requested.	0 680		

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	30560	A. BUILDING: _____ B. WING _____	10/14/2021

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0 680	Continued From page 13 The facility's plan consisted of corporate documents contained in a red three-ringed binder titled "Emergency Preparedness Manual." T he plan lacked the customized Appendix Z required content to include: - A facility-based and community-based risk assessment utilizing an all-hazards approach; - A customized documented plan for evacuation and identified relocation sites; - Detailed staff assignments in the event of a disaster or an emergency; - The medical record documentation system to preserve resident information; - Procedure for tracking staff and residents; - Address the elements of sheltering in place; - Emergency training and testing program; - Emergency training program for staff (including the documentation of training provided); - Emergency testing/annual testing requirements; - A communication plan that included arrangement with other facilities; - An updated name and contact information for staff; and - A method of sharing information from the emergency plan with residents and their families. On October 12, 2021, at approximately 2:00 p.m. licensed assisted living director (LALD)-A acknowledged the facility's current emergency preparedness plan was not complete. A policy was requested, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 14 (21) days.	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	0 810		

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0 810	Continued From page 15 by: Based on interview and record review, the licensee failed to provide fire safety and evacuation training at least once per year to residents who are capable of assisting in their own evacuation, and failed to require evacuation drills twice per year per shift with at least one evacuation drill every other month, as required by MN Statute 144G.45, Subd.2 (e) and (f). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 13, 2021, between 12:50 p.m. and 1:15 p.m. an interview and record review was conducted with the Maintenance Technician (MT)-A on fire safety and evacuation training for residents who are capable of assisting in their own evacuation. The facility lacked evidence of providing residents training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation at least one time per year. MT-A verified they did not provide specific training to the residents as required. The training of residents who are capable of assisting in their own evacuation can greatly increase evacuation times for all members of the facility in an emergency situation.	0 810		

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0 810	Continued From page 16 In addition, the licensee lacked evidence of conducting any evacuation drills for employees. MT-A verified the licensee has not performed evacuation drills as required. MT-A further indicated not being aware of any policies regarding evacuation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=D	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, licensee failed to ensure orientation training to assisted living licensing requirements and regulations was provided for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01460		

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01460	Continued From page 17 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: RN-A began providing clinical nursing services on August 1, 2021, at various assisted living facilities within the district. On October 14, 2021, at approximately 12:45 p.m. RN-A provided direct care services for an unidentified resident, which included behavior management/redirection. RN-A's employee records did not contain documentation RN-A completed orientation to the assisted living facility licensing requirements and regulations before providing assisted living services to residents. On October 14, 2021, at approximately 1:03 p.m. RN-A confirmed RN-A did not complete orientation to the assisted living facility licensing requirements and regulations as required. The licensee's Orientation and Annual Training Requirements policy revised August 2021, indicated staff/associates providing and supervising direct Assisted Living services should complete an orientation prior to providing Assisted Living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		

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01620	Continued From page 18	01620		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1), in addition the facility failed to conduct a timely 14-day assessment for one of two residents (R2) with records reviewed.	01620		

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01620	Continued From page 19 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 - 90 DAY ASSESSMENT R1's diagnoses included, but were not limited to hypertension (high blood pressure) and depression disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.) R1's Service Plan dated July 12, 2021, indicated services included medication administration, dressing/grooming, chronic condition management, respiratory equipment, nutrition, showers, bathroom assistance, escort/mobility, two-person transfer, cognitive/psychosocial, behavior management, skin care, and service coordination. R1's record included a Personnel Service Assessment dated April 1, 2021, and July 12, 2021, which was 12 days overdue. On October 13, 2021, at approximately 8:24 a.m. unlicensed personnel (ULP)-A was observed to administer oral medications to R1. On October 13, 2021, at approximately 1:48 p.m. registered nurse (RN)-A confirmed R1's assessment dates and confirmed the 90-day assessment was 12 days overdue.	01620		

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01620	Continued From page 20 R2 - 14 DAY ASSESSMENT R2's diagnoses included, but were not limited to hypertension (high blood pressure), depressive disorder, unspecified dementia (memory loss), atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), diabetes, osteoporosis(a condition in which bones become weak and brittle) and multiple fractures of the pelvis. R2 was admitted for services on Septemeber 9, 2021. R2's Service Plan dated October 11, 2021, indicated services included medication administration, chronic disease management, bathing or showers, and service coordination. R2's record included Personal Service Assessments were dated September 9, 2021, and October 11, 2021, which was 18 days overdue. On October 13, 2021, at approximately 7:53 a.m. ULP-A was observed to administer oral medications to R2. On October 13, 2021, at approximately 1:50 p.m. RN-A confirmed R2's assessment dates, and confirmed the 14-day assessment was 18 days overdue. The licensee's Evaluation Process Policy revised August 2021, indicated a registered nurse should complete a personal service assessment (PSA) prior to signing a contract date or move in, whichever is earliest; no more than 14 days after moving in; and at least every 90 days or change of condition.	01620		

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01620	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R2) receiving blood glucose monitoring with	01950		

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01950	Continued From page 22 records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included, but were not limited to, diabetes mellitus type 2, unspecified dementia, and multiple fractures of the pelvis. R2's service plan dated September 9, 2021, indicated services included medication administration, chronic disease management, bathing or showers, and service coordination. R2's record titled "Minnesota Treatment or Therapy Management Service Plan" dated September 9, 2021, indicated blood glucose monitoring may be delegated to a trained unlicensed personnel (ULP) or licensed nurse. Comment section: Once daily and as needed for signs of hypoglycemia or hyperglycemia. Staff to report to nurse if BS is <60. R2's physician order dated September 16, 2021, indicated daily fingerstick, blood sugar. R2's October 2021, medication administration record (MAR) indicated a start date October 13, 2021, to check blood sugar daily, resident will check blood sugar and will report to medication technician to record in Point Click Care (PCC), one time a day related to TYPE 2 DIABETES	01950		

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01950	Continued From page 23 MELLITUS. The MAR lacked the blood glucose parameters as to when to contact the RN or provider or specific "as needed" directions for signs and symptoms of hypoglycemia and hyperglycemia. The MAR did not contain any recorded glucose values. On October 13, 2021, at approximately 9:25 a.m. unlicensed personnel (ULP)-A stated they had just started documenting R2's sugars "today." ULP-A further stated he was not aware of set parameters but R2's sugars had always been high. On October 13, 2021, at approximately 9:35 a.m. RN-A acknowledged R2's MAR had lacked the treatment direction to record R2's blood sugar readings, and the direction was added to the MAR today. RN-A stated staff were to contact the RN if glucose readings were below 60. On October 13, 2021, at approximately 10:35 a.m. R2 stated her biggest concern was her diabetes and her medications. R2 stated and verified she performed her own glucose checks daily and informed the staff of the reading. The licensee's Treatment or Therapy Management Services policy dated November 2018, indicated LPNs or ULP should follow resident specific instructions for treatment(s) as indicated on Therapy or Treatment Management Plan and Delegated Tasks sheets. Documentation of the services should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR). No further information was provided.	01950		

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01950	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure treatments were performed as ordered for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included, but were not limited to, diabetes mellitus type 2, unspecified dementia, and multiple fractures of the pelvis.	01960		

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01960	Continued From page 25	01960		

R2's service plan dated September 9, 2021, indicated services included medication administration, chronic disease management, bathing or showers, and service coordination.

R2's record titled "Minnesota Treatment or Therapy Management Service Plan" dated September 9, 2021, indicated blood glucose monitoring may be delegated to a trained ULP or licensed nurse. Comment section: Once daily and as needed for signs of hypoglycemia or hyperglycemia. Staff to report to nurse if BS is <60.

R2's physician order dated September 16, 2021, indicated daily fingerstick, blood sugar.

R2's October 2021, medication administration record (MAR) indicated a start date of October 13, 2021, to check blood sugar daily, resident will check blood sugar and will report to medication technician to record in Point Click Care (PCC), one time a day related to TYPE 2 DIABETES MELLITUS. The MAR lacked the blood glucose parameters as to when to contact the RN or provider or specific "as needed" directions for signs and symptoms of hypoglycemia and hyperglycemia. The MAR did not contain any recorded glucose values.

On October 13, 2021, at approximately 9:25 a.m. unlicensed personnel (ULP)-A stated they had just started documenting R2's sugars "today." ULP-A stated he was not aware of set parameters, but R2's sugars had always been high.

On October 13, 2021, at approximately 9:35 a.m. RN-A acknowledged R2's MAR had lacked the

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01960	Continued From page 26 treatment direction to record R2's blood sugar readings, and the direction was added to the MAR today. RN-A stated that staff were to contact the RN if glucose readings were below 60. On October 13, 2021, at approximately 10:35 a.m. R2 stated her biggest concern was her diabetes and her medications. R2 stated and verified she performed her own glucose checks daily and informed the staff of the reading. The licensee's Treatment or Therapy Management Services policy dated November 2018, indicated that LPNs or ULP should follow resident specific instructions for treatment(s) as indicated on Therapy or Treatment Management Plan and Delegated Tasks sheets. Documentation of the services should be noted on the ADL sheet or Medication Administration Record (MAR/eMAR)/Treatment Administration Record (TAR/eTAR). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01960		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30560	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MANKATO	100 TETON LANE MANKATO, MN 56001

(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
03090	Continued From page 27 subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On August 12, 2021, at approximately 9:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On August 12, 2021, at 11:38 a.m. licensed assisted living director (LALD)-A stated the door entered was the main door utilized, and confirmed no posting was available related to the statutory language for electronic monitoring. The licensee's Electronic Monitoring policy dated January 2020, indicated the licensee must post a sign at each community entrance accessible to visitors.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30560	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MANKATO	**100 TETON LANE MANKATO, MN 56001**

(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
03090	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *10/12/21*
Time: 16:08:31
Report: 1028211035

Food and Beverage Establishment Inspection Report

Location:
Brookdale Mankato
100 Teton Ln
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: N000003
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Geri Svaleson
Phone #:
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

A Certified Food Protection Manager (CFPM) must be employed by this establishment.

Comply By: 10/12/21

6-100 Physical Facility Construction Materials

6-101.11A1

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

Provide stainless steel or ceramic surfaces on the wall behind the stove. The wall is currently just drywall.

Comply By: 12/31/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: True Freezer
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: 2 Degrees Fahrenheit - Location: Arctic Air Freezer
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Salami
Violation Issued: No

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

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

This Inspection was conducted in conjunction with HRD's Inspection.

Joann Meyer was provided with information on the process for obtaining an Initial CFPM license, including where to search for upcoming classes.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028211035 of 10/12/21.

Certified Food Protection Manager: Pending

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Geri Svaleson
Executive Director

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us