Electronically Delivered

January 31, 2025

Licensee
Lange Board and Room, Inc.
13892 37th Street
Clear Lake, MN 55319

RE: Project Number(s) SL33606015

Dear Licensee:

On November 19, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 22, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 22, 2024, survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 22, 2024, found not corrected at the time of the November 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on November 19, 2024 (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.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

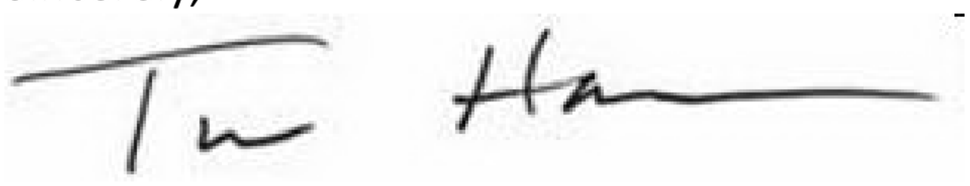
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,



Tim Hanna, Supervisor
State Engineering Services Section
Email: 507-208-8982
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	R 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL33606015-1 On November 19, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 22, 2024. At the time of the survey, there were 29 residents; 29 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	{0 250}		

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{0 250}	Continued From page 1 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 staff 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 staff; (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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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	{0 250}		

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{0 250}	Continued From page 2 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: Not reviewed during this survey.	{0 250}	Not reviewed during this survey.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living	{0 460}		

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{0 460}	Continued From page 3 facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 460}	Not reviewed during this survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	{0 480}		

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{0 480}	Continued From page 4 storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}	Not reviewed during this survey.	
{0 510} SS=D	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	{0 510}		

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{0 510}	Continued From page 5 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}	Not reviewed during this survey.	
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 570}	Not reviewed during this survey.	
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 630}	Not reviewed during this survey.	

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{0 650}	Continued From page 6	{0 650}		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}	Not reviewed during this survey.	
{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	{0 660}		

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{0 660}	Continued From page 7 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: Not reviewed during this survey.	{0 660}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	{0 680}		

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{0 680}	Continued From page 8 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: Not reviewed during this survey.	{0 680}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}	Not reviewed during this survey.	
{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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}		

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{0 810}	Continued From page 9 (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) Staff 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 staff 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: Not reviewed during this survey.	{0 810}	Not reviewed during this survey.	
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	{0 820}		

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{0 820}	Continued From page 10 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 November 19, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on August 22, 2024. The surveyor met with director of maintenance/ unlicensed personnel (DM/ULP)-F to review the status of the non-complying egress windows. The noncompliant measurements from the initial survey were as follows: OCCUPIED SLEEPING ROOMS:	{0 820}		

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{0 820}	Continued From page 11 Bedroom 9: Two windows measuring 21 3/4 inches clear width, 27 1/5 inches clear height, and 598 square inches total open area for each window. Bedroom 10/11: Two windows measuring 20 5/8 inches clear width, 27 1/2 inches clear height, and 567 square inches total open area for each window. Bedroom 12/13: One window measuring 14 1/2 inches clear width, 48 inches clear height, and 696 square inches total open area for each window. Bedroom 14/15: Two windows measuring 20 1/2 inches clear width, 27 1/2 inches clear height, and 563 3/4 square inches total open area for each window. Bedroom 16/17: Two windows measuring 24 3/4 inches clear width, 23 inches clear height, and 569 1/4 square inches total open area for each window. Bedroom 18/19: Two windows measuring 25 inches clear width, 25 inches clear height, and 625 square inches total open area for each window. Bedroom 20/21: Two windows measuring 23 inches clear width, 22 inches clear height, and 506 square inches total open area for each window. Bedroom 22/23: Two windows measuring 22 1/2 inches clear width, 22 inches clear height, and 495 square inches total open area for each window. Bedroom 24/25: Two windows measuring 22 inches clear width, 21 1/2 inches clear height, and 473 square inches total open area for each window. Bedroom 26/27: Two windows measuring 22 inches clear width, 21 inches clear height, and 462 square inches total open area for each window.	{0 820}		

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{0 820}	Continued From page 12 Bedroom 28: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. Bedroom 30/31: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. Bedroom 32/33: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. The windows in bedrooms 12/13, 28, 30/31, and 32/33 did not meet the minimum requirements for opening width. The windows in bedrooms 9, 10/11, 14/15, 16/17, 18/19, 20/21, 22/23, 24/25, 26/27, 28, 30/31, and 32/33 did not meet the minimum requirements for the total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On November 19, 2024 at 12:30 p.m. DM/ULP-F stated they were waiting on the local authority having jurisdiction (AHJ) to approve their construction permit to build an addition which would include a new sprinkler system for the entire building. During the same interview, licensed assisted living director/ licensed practical nurse (LALD/LPN)-A provided survey staff with the licensee's fire watch log. The licensee has maintained a continuous fire watch log from the initial issue of the immediate order on August 22, 2024, to the current date of the follow-up survey.	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	R 11/19/2024

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{0 820}	Continued From page 13 No additional information was provided.	{0 820}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}	Not reviewed during this survey.	
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	{01060}		

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{01060}	Continued From page 14 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01060}	Not reviewed during this survey.	
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	{01470}		

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{01470}	Continued From page 15 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	{01470}		

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{01470}	Continued From page 16 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01470}	Not reviewed during this survey.	
{01500} SS=F	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; (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	{01500}		

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{01500}	Continued From page 17 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 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: Not reviewed during this survey.	{01500}	Not reviewed during this survey.	
{01890} SS=F	144G.71 Subd. 20 Prescription drugs	{01890}		

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{01890}	Continued From page 18 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: Not reviewed during this survey.	{01890}	Not reviewed during this survey.	
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state 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: Not reviewed during this survey.	{01910}	Not reviewed during this survey.	

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{02310} SS=F	144G.91 Subd. 4 (a) 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: Not reviewed during this survey.	{02310}	Not reviewed during this survey.	
{02320} SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02320}	Not reviewed during this survey.	
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced	{03090}		

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{03090}	Continued From page 20 by: Not reviewed during this survey.	{03090}	Not reviewed during this survey.	

Electronically Delivered

September 25, 2024

Licensee
Lange Board And Room Inc.
13892 37th Street
Clear Lake, MN 55319

RE: Project Number(s) SL33606015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33606015-0 On August 19, 2024, through August 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 29 residents; 29 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 21, 2024, issued for SL33606015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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;	0 250		

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0 250	Continued From page 2 (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, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 19,	0 250		

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0 250	Continued From page 3 2024, at 10:50 a.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent LALD/LPN-A, 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. - 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	0 250		

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	33606	A. BUILDING: _____ B. WING _____	08/22/2024

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LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

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0 250	Continued From page 4 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 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	0 250		

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0 250	Continued From page 5 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 six was electronically signed by authorizing agent LALD/LPN-A on May 24, 2024. The licensee had an assisted living license issued on August 1, 2024, with an expiration date of July 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance -orientation to and implementation of the assisted living bill of rights; -infection control practices -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards -medication management As a result of this survey, the following orders were issued 0250, 0460, 0480, 0510, 0570, 0630, 0650, 0660, 0680, 0800, 0810, 0820, 0970, 1060, 1470, 1500, 1890, 1910, 2310, 2320, 3090	0 250		

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0 250	Continued From page 6 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		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed allow residents to choose the resident's visitors and times of visits. This had the potential to affect all residents and	0 460		

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0 460	Continued From page 7 visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 held an assisted living license and was licensed for a capacity of 34 residents, with a census of 29 residents. During the entrance conference on August 19, 2024, at 10:50 a.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated Resident Agreement (assisted living contract) included the following clause that did not allow residents to have visitors at any time: -page eight: Section 14 Occupancy and Use of the Apartment subp C: Visitors: You (resident) are free to receive visitors at times of your choosing. The Community (facility) does have restricted visiting hours from 10pm-8am [sic]. On August 19, 2024, at 2:25 p.m., LALD/LPN-A stated the licensee did not allow visitors from 10:00 p.m. until 8:00 a.m., daily due to mental health needs of residents and the licensee had received several complaints of noise after 10:00 p.m.	0 460		

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0 460	Continued From page 8 On August 20, 2024, at 9:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee did not allow visitors at the facility from 10:00 p.m. until 8:00 a.m. daily. CNS-B further stated the licensee considered the overnight time as "quiet time" to respect all residents residing at the facility, and CNS-B could not recall a time when a resident requested to have a visitor overnight. CNS-B further stated the licensee was not aware visiting hours could not be restricted. The licensee's Resident Visiting Hours policy dated October 9, 2023, indicated residents were able to visit with family and friends at any point between the hours of 8am-10pm [sic]. No overnight visitors are allowed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 9 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure services were provided according to accepted health care, medical or nursing standards in regard to infection control for one of two employees (unlicensed personnel (ULP)-D).	0 510		

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0 510	Continued From page 10 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 19, 2024, at 10:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents. On August 20, 2024, at 7:04 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D took out R4's weekly mediplanner (a multicompartment container for storing scheduled doses of medications), opened the Tuesday morning slot, flipped over the mediplanner for the medications to be placed in a paper cup, and brought the paper cup to R4. During medication administration for R4, one of R4's medications fell onto the office floor. R4 stated "five second rule", ULP-D immediately picked up the medication off the floor and handed the medication back to R4. ULP-D then offered to go get a new medication that had not fallen on the floor, however, R4 declined. On August 20, 2024, at 8:09 a.m., ULP-D stated ULP-D should have reported to LALD/LPN-A after R4's medication fell onto the floor and administered a new medication to R4, however, R4 was getting upset so ULP-D decided to	0 510		

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0 510	Continued From page 11 administer the medication off the floor. ULP-D further stated the office floor was not a clean area. On August 20, 2024, at 8:54 a.m., LALD/LPN-A stated if a medication falls on the floor, ULPs should place the medication in a paper cup, notify the nurse for proper destruction, and administer a new medication from the pharmacy. LALD/LPN-A further stated the office floor was not sanitary. On August 20, 2024, at 9:31 a.m., clinical nurse supervisor (CNS)-B stated if a medication drops on the floor, ULPs should contact the nurse for proper destruction, and administer a new medication to the resident. CNS-B further stated the office floor was kept clean daily. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current assisted living license at the main entrance of each assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors.	0 570		

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0 570	Continued From page 12 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 19, 2024, from 11:55 a.m. through 12:20 p.m., the surveyor toured the campus consisting of two buildings (Main House and Cottages) that housed residents with director of maintenance/unlicensed personnel (DM/ULP)-D. The Main House had two original licenses posted consisting of one with the address of 13892 37th Street with a capacity of 25 residents (Main House), and one with the address of 13896 37th Street with a capacity of nine residents (Cottages). There was no assisted living license observed to be posted at the Cottages. On August 19, 2024, at 12:59 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was not aware the original license for each assisted living needed to be posted in the main entry way for the corresponding assisted living since the licensee only had an office located at the Main House for residents, staff, and visitors to check into. The licensee's Business Operation policy dated October 5, 2023, indicated the original current license must be displayed at the main entrance of each assisted living facility. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0040, Subp. 2, effective October	0 570		

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0 570	Continued From page 13 2022, the facility must post the original license certificate issued by the commissioner at the main public entrance of the facility. A campus with multiple buildings must post the original certificate issued by the commissioner at the main public entrance of each building licensed as a facility on the campus. A separate license certificate shall be issued for each building on the campus. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, R4, R6). This practice resulted in a level two violation (a	0 630		

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0 630	Continued From page 14 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: During the entrance conference on August 19, 2024, at 10:50 a.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included intellectual disability, diabetes, and arthritis (joint inflammation). R2's service plan dated July 25, 2024, indicated R2 received medication administration, blood glucose checks, compression stockings (TEDS), behavior management, and housekeeping. On August 20, 2024, at 5:51 a.m., the surveyor observed unlicensed personnel (ULP)-D provide scheduled morning medication administration to R2. R2's IAPP dated August 13, 2024, identified areas of vulnerability for R2's risk of being abused, R2's risk of abusing other vulnerable adults, and risk for self-abuse, however, R2's record lacked statements of specific measures to be taken to minimize the risk of abuse in each area noted above. R4 R4's diagnoses included hypertension (HTN-high	0 630		

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0 630	Continued From page 15 blood pressure) and congestive heart failure (CHF). R4's service plan dated July 15, 2024, indicated R4 received medication administration, vital sign monitoring, behavior management, toileting, and housekeeping. On August 20, 2024, at 7:04 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. R4's IAPP dated August 14, 2024, identified areas of vulnerability for R4's risk of being abused, R4's risk of abusing other vulnerable adults, and risk for self-abuse, however, R4's record lacked statements of specific measures to be taken to minimize the risk of abuse in each area noted above. R6 R6's diagnoses included diabetes, bipolar one severe with psychotic features, and HTN. R6's service plan dated July 15, 2024, indicated R6 received medication administration, blood glucose checks, behavior management, bathing, and housekeeping. On August 20, 2024, at 7:25 a.m., the surveyor observed ULP-D provide schedule morning medication administration to R6. R6's IAPP dated August 14, 2024, identified areas of vulnerability for R6's risk of being abused, R6's risk of abusing other vulnerable adults, and risk for self-abuse, however, R6's record lacked statements of specific measures to be taken to minimize the risk of abuse in each area noted above.	0 630		

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0 630	Continued From page 16 On August 21, 2024, at 9:58 a.m., LALD/LPN-A stated the licensee had a change over in staff and new staff were not properly trained on all the requirements of an IAPP. On August 21, 2024, at 11:57 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware of the requirement in an IAPP to write down specific measures taken to minimize the risk of abuse in each area. CNS-B further stated the licensee had monitored resident behaviors and provided redirection to each resident as needed to reduce the risk of abuse. The licensee's undated IAPP policy indicated the IAPP would include specific measures to minimize the risk of abuse to that person (resident) and other vulnerable adults. In addition, measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	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	0 650		

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0 650	Continued From page 17 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-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) 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 19, 2024, at 11:01 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was aware of required contents for an employee record. ULP-C was hired on January 26, 2024, to provide	0 650		

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	33606	A. BUILDING: _____ B. WING _____	08/22/2024

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0 650	Continued From page 18 direct care assisted living services. Throughout the survey, the surveyor observed ULP-C provide direct assisted living services to residents. ULP-C's employee record contained an Orientation Checklist dated January 26, 2024, which indicated competency evaluation was completed, however, ULP-C's employee record lacked competency evaluations for oxygen, compression stockings (TEDS), ace wraps, blood glucose, modified diets, and unplanned time away. On August 19, 2024, at 12:43 p.m., ULP-C stated ULP-C was trained and completed competency testing by clinical nurse supervisor (CNS)-B after being hired at the assisted living facility. On August 20, 2024, at 8:39 a.m., LALD/LPN-A stated the registered nurse (RN) completes all trainings and competency testing to all ULPs upon hire and the records are then placed into the employee's file. LALD/LPN-A further stated LALD/LPN-A was unable to locate ULP-C's competency testing for oxygen, TEDS, ace wraps, blood glucose, modified diets, and unplanned time away and the competency form for ULP-C must have been misplaced. On August 20, 2024, at 9:26 a.m., CNS-B stated CNS-B completed all training and deemed ULP-C competent for all delegated treatments as noted above and should have been documented on the competency form. CNS-B further stated unplanned time away training and competency was completed for ULP-C upon hire. No further information was provided.	0 650		

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0 650	Continued From page 19 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 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 observation, 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) and Minnesota Department of Health (MDH), which included completion of a TB facility risk assessment. In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C).	0 660		

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0 660	Continued From page 20 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 19, 2024, at 10:50 a.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. TB RISK ASSESSMENT The licensee provided a Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated August 1, 2022, and was completed by LALD/LPN-A. On page three, section: Quality Improvement: 2: indicated the TB risk assessment was conducted or updated yearly by the licensee. On August 19, 2024, at 11:23 a.m., LALD/LPN-A stated the licensee had been working on an updated TB risk assessment, however, had not completed the worksheet yet. On August 20, 2024, at 9:21 a.m., CNS-B stated the licensee had not updated the TB risk assessment since 2022 and the TB risk assessment should be completed yearly. TB SCREENING CNS-B CNS-B was hired on November 18, 2023, to	0 660		

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0 660	Continued From page 21 provide direct care services and supervision of staff at the assisted living facility. CNS-B's record lacked a baseline TB screening. CNS-B record contained a negative TST administered May 24, 2023 (178 days prior to employment), however, lacked evidence of a two-step TST or TB blood test completed within 90 days prior to employment. ULP-C ULP-C was hired on January 26, 2024, to provide direct care services to residents at the assisted living facility. Throughout the survey, the surveyor observed ULP-C provide direct care assisted living services to residents. ULP-C's record included documentation of a baseline TB screening for active TB dated January 30, 2024. ULP-C had two negative TSTs administered January 30, 2024, and March 23, 2024 (53 days apart), respectively, however, the second TST was not administered within the seven to 21-day time frame required. The licensee's Exposure to Tuberculosis policy dated August 22, 2023, indicated a TB risk assessment must be completed. In addition, all healthcare workers should receive a baseline TB screening upon hire using the two-step TST or a single blood test. 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 risk assessment should be completed initially and then for low-risk settings the risk assessment	0 660		

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0 660	Continued From page 22 should be updated every other year. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 23 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 develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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's EPP dated July 28, 2023, lacked the following content and/or policies and procedures to address: -a completed hazards risk assessment; - annual review of the EPP; - a quarterly review of the missing resident policy; -man-made disasters; -infectious disease; - shelter in place;	0 680		

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0 680	Continued From page 24 - development of policies/procedures to address: - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; -emergency officials contact information to include federal, regional, and local EP staff, and state licensing and certification agency; - arrangement with other facilities with signed memorandums of agreement; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; - a method of sharing information from the EPP with residents and their families; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On August 21, 2024, at 11:39 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee had only completed a partial hazardous assessment and the EPP was a work in progress. LALD/LPN-A further stated the missing resident plan was reviewed annually, however, LALD/LPN-A stated the licensee was not aware the missing resident	0 680		

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0 680	Continued From page 25 plan needed to be reviewed at least quarterly. The licensee's Emergency Preparedness policy dated August 7, 2023, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated August 8, 2023, did not indicate how often the Missing Resident policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the LALD and clinical nurse supervisor (CNS) must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 26	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 August 21, 2024, from approximately 10:15 a.m. to 1:30 p.m., survey staff toured the facility with director of maintenance/ unlicensed personnel (DM/ULP)-F. The following was observed.	0 800		

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0 800	Continued From page 27 MAIN HOUSE: The double-hung window in bedroom 10/11 was broken and would crash down if the locks were not engaged. The basement storage room had multiple electrical j-boxes without covers. SMALL HOUSE: Lower level bathroom had water damage to the ceiling above the shower. The sealants at the floor to wall transition and around the toilet were damaged and heavily stained. The stairs to the upper level had three nails protruding on the risers that had been hammered at an angle, but were still extending into the tread enough to be a tripping hazard. The dining room and living room had a smoke alarm removed and the opening in the wall was left uncovered exposing the wiring to the rooms. On August 21, 2024, at 1:30 p.m., DM/ULP-F stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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;	0 810		

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0 810	Continued From page 28 (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 observation, interview, and record review, the licensee failed to provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 810		

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0 810	Continued From page 29 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 21, 2024, licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/LPN-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/LPN-A lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On August 21, 2024, at 3:30 p.m., LALD/LPN-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month.	0 810		

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0 810	Continued From page 30 Record review of licensee's evacuation drill logs indicated evacuation drills were conducted on May 3, 2024, February 8, 2024, October 11, 2023, August 1, 2023, April 25, 2024, February 6, 2023, October 13, 2022, and August 5, 2022. No other documentation was provided. On August 21, 2024, at 3:30 p.m., LALD/LPN-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum	0 820	This immediate correction order identified on August 21, 2024, has had the immediacy lifted as of August 21, 2024, however non-compliance remained a scope and level of H.	

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0 820	Continued From page 31 state standard for egress. This had the potential to affect some residents, staff, and visitors. 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 21, 2024, from approximately 10:30 a.m. to 1:30 p.m., survey staff toured the facility with director of maintenance/ unlicensed personnel (DM/ULP)-F. During the tour, survey staff asked DM/ULP-F to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 9: Two windows measuring 21 3/4 inches clear width, 27 1/5 inches clear height, and 598 square inches total open area for each window. Bedroom 10/11: Two windows measuring 20 5/8 inches clear width, 27 1/2 inches clear height, and 567 square inches total open area for each window. Bedroom 12/13: One window measuring 14 1/2 inches clear width, 48 inches clear height, and 696 square inches total open area for each window. Bedroom 14/15: Two windows measuring 20 1/2 inches clear width, 27 1/2 inches clear height, and 563 3/4 square inches total open area for each window. Bedroom 16/17: Two windows measuring 24 3/4	0 820		

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	33606	A. BUILDING: _____ B. WING _____	08/22/2024

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0 820	Continued From page 32 inches clear width, 23 inches clear height, and 569 1/4 square inches total open area for each window. Bedroom 18/19: Two windows measuring 25 inches clear width, 25 inches clear height, and 625 square inches total open area for each window. Bedroom 20/21: Two windows measuring 23 inches clear width, 22 inches clear height, and 506 square inches total open area for each window. Bedroom 22/23: Two windows measuring 22 1/2 inches clear width, 22 inches clear height, and 495 square inches total open area for each window. Bedroom 24/25: Two windows measuring 22 inches clear width, 21 1/2 inches clear height, and 473 square inches total open area for each window. Bedroom 26/27: Two windows measuring 22 inches clear width, 21 inches clear height, and 462 square inches total open area for each window. Bedroom 28: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. Bedroom 30/31: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. Bedroom 32/33: One window measuring 19 inches clear width, 42 3/4 inches clear height, and 812 1/4 square inches total open area. The windows in bedrooms 12/13, 28, 30/31, and 32/33 did not meet the minimum requirements for opening width. The windows in bedrooms 9, 10/11, 14/15, 16/17, 18/19, 20/21, 22/23, 24/25, 26/27, 28, 30/31, and 32/33 did not meet the minimum requirements for	0 820		

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0 820	Continued From page 33 the total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to DM/ULP-F that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On August 21, 2024, survey staff explained to DM/ULP-F that an immediate correction order was issued for the above findings. DM/ULP-F stated they understood the requirements for egress windows and stated that the facility was planning to install a sprinkler system in 2024. TIME PERIOD FOR CORRECTION: Immediate. Immediacy is removed as confirmed by surveyor supervisor on August 22, 2024, at 6:20 a.m., however, non-compliance remains at a scope and level of three, widespread (I).	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 34 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. 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 the potential to affect a large portion or all the residents). The findings include: The licensee's undated Resident Agreement (assisted living contract), included the following clauses that a resident would waive the facility's liability for health, safety, or personal property of the resident: -page 10 Section 15 Resident's Use of the Facilities subp N: To pay the Community (facility) for any loss or damage to the unit, building or grounds caused by you (resident) ..., normal wear and tear excepted [sic]; and -page 27 Miscellaneous Provisions: Any Damage [sic] willfully or negligently incurred by the resident ... will be the responsibility of the resident to cover. The bill for the damage will need to be paid in full on or before discharge. On August 19, 2024, at 2:54 p.m., licensed assisted living director/ licensed practical nurse (LALD/LPN)-A stated the same assisted living	0 970		

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0 970	Continued From page 35 contract was used for all residents. LALD/LPN-A further stated the licensee purchased the assisted living contract from a private vendor to use and LALD/LPN-A was not sure if the above noted sections was language waiving the facility's liability for health, safety, or personal property. LALD/LPN-A further stated the licensee would only require a resident to pay for damages if the resident did the damages intentionally. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 36 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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 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	01060		

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01060	Continued From page 37 of the residents). The findings include: During the entrance conference on August 19, 2024, at 10:50 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated Discharged Resident/ Client Roster dated August 19, 2024, indicated R1 was admitted on December 12, 2022, and was discharged on July 16, 2024. R1's Service Plan dated May 17, 2024, indicated R1 received medication administration, behavior management, housekeeping, and laundry. R1's Resident Notes- One Resident included the following: -June 11, 2024, at 12:01 p.m., indicated R1 went to the hospital with EMS (emergency medical services) and a police escort. -June 12, 2021, at 1:01 p.m., indicated R1 was discharged from the hospital and was being admitted to CBHH (community behavioral health hospital). -July 26, 2024, at 1:41 p.m., R1 remained at CBHH and would be moving to a group home setting. R1's Assessment by Date Discharge/Transfer dated July 31, 2024, indicated R1 continued to reside at CBHH with an unknown ETA (estimated time of arrival). R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 38 - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On August 21, 2024, at 9:41 a.m., LALD/LPN-A stated an emergency relocation was not completed on R1. LALD/LPN-A stated the licensee was aware of the emergency relocation requirement, however, the licensee was not aware the emergency relocation needed to be sent to the OOLTC if a resident had not returned to the facility within four days. On August 21, 2024, at 11:55 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was not familiar with the emergency relocation requirement and CNS-B did not complete an emergency relocation for R1. The licensee's Contract Terminations and Prerequisite to Terminations/ Emergency Relocation policy dated August 7, 2024, indicated when a facility enacts an emergency relocation, the facility must deliver, as soon as practicable, a written notice to the resident, their legal	01060		

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01060	Continued From page 39 representative, and their designated representative. The notice must be delivered to the resident's case manager if the resident is receiving home and community-based waiver services. The notice must also be delivered to the Office of Ombudsman for Long Term Care as soon as practicable and within 24 hours if the resident has relocated and not returned to the facility within four days. The notice must include the reason for the relocation, the name and contact information for the location and service provider where the resident is being relocated, and the contact information for the Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. The notice must also include, if known and applicable, the estimated date or date range of when the resident is expected to return to the facility. If the date or estimated date is not known, the notice must include a statement that the return date is not known. If the facility refuses to provide housing or assisted living services to the resident after their relocation, the written notice must include a statement that the resident has the right to appeal and the contact information for where the resident must submit their appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470		

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01470	Continued From page 40 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	01470		

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01470	Continued From page 41 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees (unlicensed personnel (ULP)-C, clinical nurse supervisor (CNS)-B). This had the potential to affect all 29 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 entrance conference on August 19, 2024, at 11:01 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was aware of required contents for an employee record. ULP-C	01470		

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01470	Continued From page 42 ULP-C was hired on January 26, 2024, to provide direct care services to residents at the assisted living facility. Throughout the survey, the surveyor observed ULP-C provide direct assisted living services to residents. ULP-C's employee record lacked the following required orientation content: -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 advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. CNS-B CNS-B was hired on November 18, 2023, to provide direct care services and supervision of staff at the assisted living facility. CNS-B's employee record lacked the following required orientation content: -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,	01470		

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01470	Continued From page 43 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 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 20, 2024, at 8:31 a.m., LALD/LPN-A stated all employees completed the same orientation to assisted living and all employee records lacked the required content of orientation to assisted living noted above. LALD/LPN-A further stated the licensee was not aware of all required content in orientation to assisted living. The licensee's Orientation and Annual Training Requirements policy dated March 12, 2024, indicated all staff providing and supervising direct home care services must complete an orientation to home care [sic] licensing requirements and regulations before providing home care [sic] services to residents. Orientation would include handling of residents' complaints, consumer advocacy services, and review types of home care [sic] services the employee would provide. The policy did not address person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01500	Continued From page 44	01500		
01500 SS=F	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; (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.	01500		

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LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(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
01500	Continued From page 45 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 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 observation, interview, and record review, the licensee failed to ensure an employee received all the required annual training content for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). 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: During the entrance conference on August 19, 2024, at 11:01 a.m., licensed assisted living	01500		

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01500	Continued From page 46 director/licensed practical nurse (LALD/LPN)-A stated the licensee was aware of required contents for an employee record. ULP-D was hired on December 8, 2017, and had begun providing direct assisted living services on August 1, 2021. On August 20, 2024, at 5:51 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R2. ULP-D's employee record lacked the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person required for annual training in 2023. On August 20, 2024, at 8:53 a.m., LALD/LPN-A stated all employees completed the same annual training and all employee records lacked principles of person-centered planning and service delivery as the licensee did not know it was a required annual training topic. The licensee's Orientation and Annual Training Requirements policy dated March 12, 2024, did not address annual training on person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 47 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the opened date and expiration date for time sensitive medications for one of one medication room. 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 19, 2024, at 10:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents. On August 20, 2024, from 8:02 a.m. until 8:04 a.m., the surveyor reviewed the locked medication storage room with unlicensed personnel (ULP)-D and observed the following: -R2's opened Breo-Ellipta 62.5 micrograms (mcg) was not labeled with an open date or expiration date; -R3's opened Lantus 100 units/milliliter (mL)	01890		

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01890	Continued From page 48 insulin pen was not labeled with an open date or expiration date; -R3's opened Advair 250/50 inhaler was not labeled with an open date or expiration date; -R6's opened Lantus 100 units/mL insulin pen was not labeled with an open date or expiration date; -R6's opened Lispro 100 units/mL insulin pen was not labeled with an open date or expiration date; -R7's opened Symbicort 80/4.5 milligrams (mg) was not labeled with an open date or expiration date; -R7's opened Spiriva 2.5 mcg was not labeled with an open date or expiration date; and -R8's opened Advair 250/50 inhaler was not labeled with an open date or expiration date. Immediately following the observation, ULP-D stated the above medications were not labeled with the open date or expiration date of the time sensitive medications, and the licensee had not been labeling any time sensitive medications. On August 20, 2024, at 8:55 a.m., LALD/LPN-A stated time sensitive medications were supposed to be labeled or staff would not know the expiration date of the medications. LALD/LPN-A further stated the licensee use to complete a review of medications every few months to monitor for expired medications. On August 20, 2024, at 9:32 a.m., clinical nurse supervisor (CNS)-B stated staff would not know the expiration date of time sensitive medications if the medications were not labeled with an opened date or an expiration date. CNS-B further stated it was the nurse's responsibility to monitor for staff labeling time sensitive medications. The manufacturer's instructions for Breo-Ellipta	01890		

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01890	Continued From page 49 dated July 2021, directed to discard the medication into the trash six weeks after opened or when the counter reads "0", whichever comes first. The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Advair dated August 2020, directed to discard the medication into the trash one month after opened, even if medication is left in it. The manufacturer's instructions for Lispro insulin pens dated February 2020, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Symbicort dated July 2019, directed to discard the medication three months after opened, even if medication is left in it. The manufacturer's instructions for Spiriva dated November 2021, directed to discard Spiriva at the latest three months after opened or when the locking mechanism is engaged, whichever comes first. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated the medication is labeled completely and legibly. In addition, the medication label should contain expiration date for time-dated drugs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 50 days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state 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 document in the resident's record the disposition of the medications with all required content for one of one resident (R1) upon discharge. 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	01910		

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01910	Continued From page 51 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 19, 2024, at 10:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents. The licensee's Discharged Resident/Client Roster dated August 19, 2024, indicated R1 was admitted to the assisted living on December 12, 2022, and discharged from the facility on July 16, 2024. R1's diagnoses included schizoaffective disorder, bipolar type with mixed features, hypertension (HTN-high blood pressure), and unspecified anxiety. R1's Service Plan dated May 17, 2024, indicated R1 received medication administration services three times per day. R1's Med (medication) Admin (administration) Summary dated June 2024, indicated R1 received the following medications: -levothyroxine (for hypothyroidism) 100 micrograms (mcg) daily -aspirin (for heart health) 81 milligrams (mg) daily -atorvastatin (for hyperlipidemia) 10 mg daily -clonazepam (for anxiety) 1 mg daily -clopidogrel (for heart health) 75 mg daily -lisinopril (for HTN) 30 mg daily -paliperidone extended release (for schizoaffective disorder, bipolar type with mixed	01910		

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01910	Continued From page 52 features) 3 mg daily -paliperidone extended release 9 mg daily -poly glycol 3350 powder (for constipation) 17 grams (gm) daily -Senna-Time (for constipation) 8.6 mg daily -vitamin D3 (supplement) 50 mcg daily R1's prescriber orders dated March 4, 2024, included the above noted medications. R1's Resident Notes-One Resident dated July 26, 2024, at 1:41 p.m., indicated R1 remained at CBHH (community behavioral health hospital) and would be moving to a group home setting. R1's Assessment by Date Discharge/Transfer dated July 31, 2024, indicated R1 continued to reside in a CBHH for mental health needs. Will adjust and redo assessment once she (R1) returns to facility. Unknown ETA (estimated time of arrival). R1's Assessment by Date Discharge/Transfer included a list of medications as of July 31, 2024, which included the medication name, strength, and how often the medication was taken. R1's record lacked documentation for the disposition of the above medications to include the 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. On August 20, 2024, at 9:46 a.m., LALD/LPN-A stated the licensee's typical process was to document on the discharge summary whom the medications were sent with and the medication disposition should be listed on R1's discharge summary.	01910		

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01910	Continued From page 53 On August 21, 2024, at 12:43 p.m., clinical nurse supervisor (CNS)-B stated when R1 was discharged from the licensee, CNS-B gave all R1's medications to R1's guardian. CNS-B further stated CNS-B was not aware of all the required content to be documented for a medication disposition and medication dispositions were documented the same for all discharged residents. The licensee's Deposition [sic] /Disposal of Unused Medications policy dated July 19, 2024, indicated medications that were secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=F	144G.91 Subd. 4 (a) 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 interview and record review, the	02310		

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02310	Continued From page 54 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 a consumer bedrail. This practice resulted in a level two violation (a violation that did not harm a client'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: R2's diagnoses included intellectual disability, diabetes, and arthritis (joint inflammation). R2's service plan dated July 25, 2024, indicated R2 received medication administration, blood glucose checks, compression stockings (TEDS), behavior management, and housekeeping. R2's Assessment by Date dated July 12, 2024, and August 13, 2024, respectively, indicated R2 had a consumer Halo style bedrail used for bed mobility independence. The bedrail was appropriate based upon R2's assessed needs, the bedrail did not function as a restraint, risk and benefits had been discussed with R2, and the bedrail met the FDA (Food and Drug Administration) guidelines. R2's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information at least every 90 days with the requirement included in the uniform assessment tool for assessing	02310		

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02310	Continued From page 55 assistive devices. On August 21, 2024, at 9:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated clinical nurse supervisor (CNS)-B completed bedrail assessments. On August 21, 2024, at 11:59 a.m., CNS-B stated CNS-B had checked for recalls on R2's consumer bedrail using the manufacturer's instructions located in the office and CNS-B registered R2's consumer bed rail to be alerted if R2's bedrail is recalled. CNS-B further stated CNS-B did not document checking the CSPC website in R2's resident chart and CNS-B was not aware checking for the bedrail recall should be documented at least every 90 days. CNS-B further stated with each 90-day assessment CNS-B ensured the consumer bed rail was secured tightly to R2's bed. The licensee's Bed Safety policy dated August 12, 2022, indicated to reassess the need for using bed rails on a frequent, regular basis. The policy did not address checking for recalls on consumer bedrails. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform	02310		

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02310	Continued From page 56 assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for two of two employees (unlicensed personnel (ULP)-D, ULP-E). 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	02320		

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02320	Continued From page 57 found to be pervasive). The findings include: During the entrance conference on August 19, 2024, at 10:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents. ULP-D On August 20, 2024, at 7:25 a.m., the surveyor observed ULP-D provided scheduled morning medication administration to R6, which included R6's insulin pens. ULP-D applied the needle to the hub of R6's Lispro 100 units/milliliter (mL) insulin pen, dialed the insulin pen to two units and discarded, dialed the insulin pen to six units, handed the insulin pen to R6, and R6 self-administered the insulin. ULP-D applied the needle to the hub of R6's Lantus 100 units/mL, dialed the insulin pen to two units and discarded, dialed the insulin pen to five units, handed the insulin pen to R6, and R6 self-administered the insulin. The surveyor did not observe ULP-D cleanse either insulin pen hub with an alcohol swab before attaching the needle or cleanse either insulin pen administration site on R6. On August 20, 2024, at 8:11 a.m., ULP-D stated ULP-D was not trained to cleanse the hub of an insulin pen prior to attaching the needle or cleanse the administration site of the insulin pen prior to administering the insulin. On August 20, 2024, at 8:57 a.m., LALD/LPN-A stated prior to attaching a needle to the insulin pen, the hub should be cleansed with an alcohol swab. LALD/LPN-A further stated any administration site should be cleansed with an	02320		

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02320	Continued From page 58 alcohol swab prior to an insulin pen administration. On August 20, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated ULPs were trained to cleanse the hub of the insulin pen with an alcohol swab prior to attaching the needle. CNS-B further stated ULPs were trained to cleanse the administration site of an insulin pen with an alcohol swab or at least offer to the resident to cleanse the site prior to the administration. The manufacturer instructions for Lispro dated February 2020, indicated to wipe the rubber seal (hub) with an alcohol swab prior to putting on the needle. The manufacturer instructions for Lantus dated May 2019, indicated to wipe the rubber seal (hub) with an alcohol prior to putting on the needle. The licensee's Medication Protocols for Insulin Pen- Reusable Pen policy dated August 1, 2021, indicated to use an alcohol wipe to clean the end of the pen where needle will be attached prior to attaching the needle. In addition, prior to administering the insulin cleanse the administration site with an alcohol swab. ULP-E On August 20, 2024, at 11:02 a.m., the surveyor observed ULP-E provide schedule medication administration to R5. ULP-E logged into R5's electronic medication administration record (EMAR) in the staff office, went to the medication room, opened the Tuesday Noon slot on R5's mediplanner (weekly medication slots set up per nurse), dumped the pills into a paper cup, returned the medication box to the shelf in the medication room, opened the lock box and	02320		

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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
02320	Continued From page 59 removed one Pregabalin pill out of R5's bubble pack (prepacked medication set up per pharmacy), placed the pill into the paper cup, and locked R5's Pregabalin bubble pack back in the lock box. ULP-E then returned to the office, handed R5 the paper cup to administer the medications, and documented on R5's EMAR the medications were verified and administered. The surveyor did not observe ULP-E compare any of the medications to the EMAR prior to the administration of R5's medications. On August 20, 2024, at 1:48 p.m., ULP-E stated ULP-E had checked R5's EMAR prior to going to the medication room to get R5's medications. ULP-E stated ULP-E confirmed the correct name and dosage of R5's Pregabalin medication bubble pack was the same as the EMAR in the staff office. On August 21, 2024, at 9:50 a.m., LALD/LPN-A stated ULPs were trained to count the number of medications to the EMAR prior to administration. LALD/LPN-A further stated when a controlled medication is being administered, ULPs should bring the bubble pack out of the medication room and into the staff office to compare the prescription label with the EMAR. On August 21, 2024, at 11:54 a.m., CNS-B stated ULPs were trained to complete three checks of comparing the EMAR to the prescription label and count the number of medications being administered from the mediplanner prior to the medication administration to residents. The licensee's Medication Administration policy dated August 7, 2022, indicated supervision of care attendants (ULPs) would include verification that medication administration is being performed	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANGE BOARD AND ROOM INC	13892 37TH STREET CLEAR LAKE, MN 55319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 60 competently and problems/solutions related to the care attendant ability to perform the services are identified. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33606	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
03090	Continued From page 61 On August 19, 2024, from 11:55 a.m. through 12:20 p.m., the surveyor toured the campus consisting of two buildings (Main House and Cottages) that housed residents with director of maintenance/unlicensed personnel (DM/ULP)-D. The Main House had a posting that indicated "Video surveillance in use on these premises." The Cottages lacked any posting regarding electronic monitoring. On August 19, 2024, at 12:57 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the assisted living buildings did not have an electronic monitoring posting with statutory language, however, the licensee provided the required electronic monitoring statutory language during resident admissions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *08/19/24*
Time: 13:01:26
Report: 7930241152

Food and Beverage Establishment Inspection Report

Location:

Lange Board And Room Inc
13892 37th Street
Clear Lake, MN55319
Sherburne County, 71

Establishment Info:

ID #: 0038963
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636622836
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.

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

STORE ALL BOXES OF FOOD IN THE WALK-IN FREEZER IN THE GARAGE UP OFF OF THE FLOOR.

Comply By: 08/19/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REPLACE DAMAGED DOOR GASKETS ON TWO DOOR FRIDGE IN THE KITCHEN AND THE TWO DOOR TRUE FRIDGE DOWNSTAIRS IN THE STORAGE ROOM.

Comply By: 10/19/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: TUNA NOODLE CASSEROLE
Violation Issued: No

Type: Full
Date: *08/19/24*
Time: 13:01:26
Report: 7930241152
Lange Board And Room Inc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: COTTO SALAMI--UPRIGHT COOLER IN KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK--DOWNSTAIRS TWO DOOR COOLER
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930241152 of 08/19/24.

Certified Food Protection Manager: JESSICA K. ITEN

Certification Number: 104338 Expires: 10/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us