



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

December 9, 2024

Licensee
St. Charles Assisted Living
402 West 4th Street
Saint Charles, MN 55972

RE: Initial License Number 411186
Health Facility Identification Number (HFID) 39776
Project Number(s) SL39776015

Dear Licensee:

On November 1, 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 May 1, 2024. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective December 9, 2024.**

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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,

A handwritten signature in black ink that reads 'Rick Michals'.

Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

September 18, 2024

Licensee
St. Charles Assisted Living
402 West 4th Street
Saint Charles, MN 55972

RE: Provisional Conditional License Number 411186
Health Facility Identification Number (HFID) 39776
Project Number(s) SL39776015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on August 26, 2024, to determine correction of orders found on the initial survey completed May 1, 2024. The follow-up survey determined your facility had not corrected the state licensing orders issued pursuant to the May 1, 2024 survey.

Based on the follow-up survey results, you were found to continue to not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for an additional 60-days, due to expire **November 17, 2024**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 1, 2024, found not corrected at the time of the August 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g) - \$500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violations noted at the time of this follow-up survey completed on August 26, 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:

MDH will issue St. Charles Assisted Living an extension to the conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if St. Charles Assisted Living is in substantial compliance.

The following conditions will remain in effect throughout the extended conditional provisional license period and apply to the provisional assisted living facility license:

- a. **Exterior locks:** St Charles Assisted Living will correct the key-only lock installed on the exterior side of the face gate.

- i. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency
 - ii. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and must default to an unlocked exiting under activation of the fire alarm, fire sprinklers or a loss of power.
- b. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if St. Charles Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines St. Charles Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to St. Charles Assisted Living. If MDH determines St. Charles Assisted Living is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Jodi Johnson directly at: 507-344-2730.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE ST CHARLES ASSISTED LIVING 402 WEST 4TH STREET SAINT CHARLES, MN 55972	(X3) DATE SURVEY COMPLETED 08/26/2024
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{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:
SL39776015-1

On August 26, 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 May 1, 2024. At the time of the survey, there were 40 residents; 40 receiving services under the Assisted Living with Dementia Care Provisional license. As a result of the follow-up survey, the following orders were reissued.

{0 820} Fire protection and physical environment
SS=F

(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.

Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees.

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

The findings include:

On August 26, 2024, at 11:30 a.m., survey staff toured the dementia care dining room and outdoor patio with registered nurse (RN)-B. During the tour, survey staff observed an illuminated exit sign posted above the door leading from the dining room to a patio enclosed by a fence. A key-only lock and top pull-style latch were installed at the top of the fence gate. RN-B opened the gate by pulling up on the latching mechanism installed at the top of the gate. During the tour interview, RN-B stated the key only lock was never used. All paths of egress must provide unobstructed exiting for the building occupants. Gate latches, locks, and other operating devices shall be installed 34 inches minimum and 48 inches maximum above the ground. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. During an interview on August 26, 2024, at 11:35 a.m., licensed assisted living director (LALD)-A verified the key only lock and latching mechanism installed on the gate.

{01620} Initial reviews, assessments, and monitoring
SS=D

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment for a change in condition following a hospitalization for one of four residents (R11).

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

The findings include:

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	NAME OF PROVIDER OR SUPPLIER, STREET ADDRESS, CITY, STATE, ZIP CODE ST CHARLES ASSISTED LIVING 402 WEST 4TH STREET SAINT CHARLES, MN 55972	(X3) DATE SURVEY COMPLETED 08/26/2024
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{01620} Continued From page 1

R11 began receiving services under the licensee's assisted living license on July 13, 2023.

R11's diagnoses included depression, asthma, stroke, and type 2 diabetes.

R11's Service Plan dated August 8, 2024, indicated she received services to include blood sugar monitoring, behavior management, toileting assistance, and safety checks.

R11's nurse progress notes indicated:

- August 5, 2024, resident has an appointment for epilepsy monitoring.
- August 7, 2024, at 8:31 a.m. resident put on hold due to being out of the building. Will resume services when resident returns.
- August 7, 2024, at 12:09 p.m. writer returned a call from social worker at the hospital regarding resident's cares being received from staff at community. Writer was informed resident was admitted for epilepsy observation. The plan is to send resident back to community today. Will update with more information when it becomes available.
- August 7, 2024, at 2:39 p.m. resident returned to community at approximately 2 PM this day. No hospital papers at this time. Resident walked right to her room without communication to staff. Will update when information regarding resident's hospital stay, if received.

R11's hospital discharge summary dated August 7, 2024, indicated she was admitted from the Epilepsy clinic for observation of her neurological spells (to rule out seizure activity).

R11's comprehensive assessments since June 1, 2024, were requested. On August 26, 2024, at 1:10 p.m. registered nurse (RN)-B provided assessments dated July 15, 2024, July 18, 2024, July 29, 2024, and August 5, 2024.

The licensee failed to ensure the registered nurse (RN) completed a change in condition assessment related to R11's hospitalization dated August 5, 2024, through August 7, 2024.

On August 26, 2024, at 3:10 p.m. RN-B stated she had updated some information in R11's comprehensive assessment dated August 5, 2024; however, no comprehensive assessment had been completed since R11's return from the hospital on August 7, 2024.

The licensee's Assessments, Review and Monitoring policy dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.

No further information was provided.



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

June 18, 2024

Licensee
St. Charles Assisted Living
402 West 4th Street
Saint Charles, MN 55972

RE: Provisional Conditional License Number 411186
Health Facility Identification Number (HFID) 39776
Project Number(s) SL39776015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 16, 2024**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

MDH will issue St. Charles Assisted Living a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if St. Charles Assisted Living is in substantial compliance.

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

- a. Exterior locks:** St Charles Assisted Living will correct the key-only lock installed on the exterior side of the face gate.
 - i. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency
 - ii. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and must default to an unlocked exiting under activation of the fire alarm, fire sprinklers or a loss of power.
- b. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if St. Charles Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines St. Charles Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to St. Charles Assisted Living. If MDH determines St. Charles Assisted Living is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after

provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Tim Hanna directly at: 507-208-8982.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, slightly slanted style.

Rick Michals, J.D.
Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39776015-0 On April 29, 2024, through May 1, 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 38 resident(s); 38 receiving services under the provider's provisional Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 1 (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 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 April 30, 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=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 510	Continued From page 2 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of three unlicensed personnel (ULP-E) during a blood sugar check and medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 30, 2024, at 6:30 a.m. ULP-E was observed to wash his hands, gather blood sugar testing equipment at the medication cart, knock on R7's door, and enter the room. ULP-E placed the blood sugar test strip in the glucometer (a device used to indicate the blood sugar level from a drop of blood), wiped R7's finger with an alcohol wipe, poked her finger with the lancet to create a drop of blood, and touched the glucometer strip to	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972		
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0 510	Continued From page 3 the drop of blood. ULP-E indicated the blood sugar level was 156, provided R7 with a tissue for the finger poke, and left the room with the glucometer, test strip and lancet carried in a plastic container. ULP-E then returned to the medication cart, disposed the blood sugar test strip and lancet in the sharp's container located at the medication cart. He wiped the glucometer with a disposable disinfectant cloth, returned it to the plastic container, placed the container with the equipment into the medication cart, locked the cart and then washed his hands at the sink. ULP-E failed to wear gloves as required during the procedure of a blood sugar check and touched multiple surfaces following the procedure. On April 30, 2024, at 7:37 a.m. ULP-E was observed to first wash his hands, then gathered blood sugar testing equipment and insulin at the medication cart for R8. ULP-E entered R8's room, wiped her finger with an alcohol wipe, poked her finger with the lancet to obtain a drop of blood, and touched the test strip to the drop of blood. ULP-E stated the blood sugar reading was 174. ULP-E then returned the blood testing equipment back to the plastic container as brought to the room. ULP-E then prepared R8's insulin pen by wiping the tip with an alcohol wipe, dialed to two units to prime the pen, dialed again to 18 units, and handed the pen to R8 who self-injected the insulin. ULP-E then gathered the plastic container with the blood testing supplies along with the insulin pen, opened the door, and touched the keypad to exit the area. ULP-E returned to the medication cart, disposed of the used testing equipment, wiped the glucometer, and placed it and the insulin pen back into the medication cart. ULP-E then went to the sink and washed his hands.	0 510			

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0 510	Continued From page 4 ULP-E failed to wear gloves as required during the procedure of a blood sugar check, failed to wash his hands following the procedure and prior to assisting R8 with her insulin pen, and touched multiple surfaces following the procedure on his way to return the equipment to the medication cart. On April 30, 2024, at 11:00 a.m., ULP-E washed his hands, gathered blood sugar testing equipment and an insulin pen, and supplies for R4. ULP-E went to R4's room, donned gloves, and completed a blood sugar check. ULP-E indicated the blood sugar was 541, which was out of range. R8 asked that ULP-E recheck it with another finger poke and finger. ULP-E obtained another drop of blood from a different finger and placed on the test strip. ULP-E indicated the blood sugar then was 258. Using the same gloves, ULP-E prepared the insulin pen by wiping the tip, placed a clean needle on the pen tip, primed with two units of insulin, and dialed to 15 units of insulin. ULP-E handed the insulin pen to R4 who self-injected the insulin. ULP-E returned the insulin pen to its storage bag, gathered the blood testing container, opened R4's door and then removed his gloves in the hallway. ULP-E returned the equipment to the medication cart and then washed his hands. ULP-E wore gloves for the blood sugar testing procedure; however, he failed to remove the gloves immediately following the blood sugar testing procedure, before assisting R4 with insulin pen preparation and administration, and touched the door handle while he left the room with the same gloves used during the entire encounter. On April 30, 2024, at 11:10 a.m. ULP-E stated he wasn't sure if he was supposed to wear gloves with blood sugar check and didn't consider the	0 510			

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0 510	Continued From page 5 number of surfaces, he had touched following completion of the task. On May 1, 2024, at 9:55 a.m. registered nurse (RN)-B indicated she expected staff to wear gloves whenever there could be contact with bodily fluids, including blood obtained with blood sugar checks. Additionally, she stated when gloves were worn during procedures, she expected staff to remove the gloves and sanitize their hands before moving onto the next task or before touching other surfaces. The licensee's Gloves policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. The licensee's Blood Sugar Testing Procedure dated August 1, 2021, indicated staff were to wash hands, and wear gloves during the blood sugar testing procedure. Staff were to dispose of the blood testing strip, remove gloves and then wash hands again. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another	0 630			

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0 630	Continued From page 6 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 (R4, R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4's diagnoses included prostate cancer with metastases to the bone (spine), Type two diabetes (when the body no longer effectively manages blood sugar and insulin) with insulin dependence, diabetic retinopathy (diabetes affecting the eyes), acquired absence (amputation) of both lower extremities below the knee with prostheses, and chronic multifocal osteomyelitis (significant bone infections). R4 was admitted to the facility under the facility's	0 630			

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0 630	Continued From page 7 Assisted Living Facility with Dementia Care on January 26, 2023. R4's Service Plan dated April 12, 2024, indicated he received the services of medication administration, blood sugar checks, safety checks, housekeeping and laundry. On April 30, 2024, at 11:00 a.m. unlicensed personnel (ULP)-E was observed to complete R4's lunch time blood sugar check and insulin administration. R4's IAPP dated April 5, 2024, in the section labeled Safety indicated R4 was not at risk to be abused. R4's IAPP included a section labeled Finance/Care Decisions with a statement which read "Needs help with financial matters and needs help with writing checks." The IAPP indicated R4's father-in-law assisted with this task. The licensee failed to recognize that R4 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. On May 4, 2024, at 1:15 p.m. registered nurse (RN)-B indicated R4's IAPP lacked clear indication of his susceptibility to abuse by others and lacked interventions to mitigate his vulnerabilities. R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors)	0 630			

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0 630	Continued From page 8 and diabetes. On April 30, 2024, at 6:36 a.m., the surveyor observed ULP-F check R1's blood sugar. R1's service plan dated April 24, 2024, indicated R1 received assistance with grooming, bathing, housekeeping, laundry, safety checks, medication administration and blood glucose checks. R1's IAPP dated March 29, 2024, identified the following areas of vulnerability: -decreased endurance/strength -unable to activate emergency call system -depression R1's IAPP did not include specific interventions for the identified vulnerabilities. R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. On April 30, 2024, at 6:42 a.m., the surveyor observed ULP-F check R2's blood sugar. R2's unsigned, service plan dated April 24, 2024, indicated R2 received assistance with dressing, grooming, bathing, toileting reminders, housekeeping, laundry, safety checks, meal reminders, medication administration, blood glucose checks and daily weights. R2's IAPP dated February 5, 2024, identified the following areas of vulnerability: -unable to activate emergency call system	0 630			

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0 630	Continued From page 9 -has difficulty using the phone -agitation -disoriented to time -risk of falling R2's IAPP did not include specific interventions for the identified vulnerabilities as required. In addition, the section labeled safety indicated R2 was not at risk to be abused. The licensee failed to recognize that R2 was a vulnerable adult and was susceptible to abuse/neglect by others. Furthermore, the licensee failed to implement interventions to minimize his abuse by others including other vulnerable adults. On May 1, 2024, at 1:26 p.m., RN-B stated R1 and R2's IAPP did not include interventions for the vulnerabilities listed above. RN-B further stated R2's IAPP should have indicated he was at risk to be abused due to being a vulnerable adult residing in memory care. The licensee's Individual Abuse Prevention policy dated August 1, 2021, indicated [licensee name] would develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided.	0 630			

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0 630	Continued From page 10	0 630			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730			

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0 730	Continued From page 11 (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's Service Plan dated April 12, 2024, indicated he received the services of medication administration, blood sugar checks, safety checks, housekeeping and laundry. On April 30, 2024, at 11:00 a.m. unlicensed personnel (ULP)-E was observed to complete R4's lunch time blood sugar check and insulin	0 730			

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0 730	Continued From page 12 administration. R4's record included a 90-day registered nurse (RN) assessment dated September 4, 2023, when the RN indicated R4 did not have pain, had no record of falls, and no recent hospitalizations. On April 30, 2024, at 11:37 a.m. the surveyor requested all nurse's notes for the previous six months for R4. The nurse's notes included the following entries: -December 14, 2023, by the licensee's licensed practical nurse (LPN)-"Resident will be returning to [facility name] on 12/19/23. Will await nurse to nurse report." -December 19, 2023, by the LPN-"Resident returned to [facility name] today around 2:30 PM. Resident was admitted to [hospital name] 11/14/23 after L3 fracture from metastatic prostate cancer. Osteomyelitis was diagnosed on left stump. Resident went back to [hospital name] for revision of left stump on 11/27/23 and returned to [skilled nursing facility name] on 12/2/23. Resident stable at discharge today. Resident is independent with all ADL's and is pivot transfer only for all transfers and does so independently. Resident only has a prosthetic for his right lower extremity. Resident is non ambulatory. Full medication management by nursing and administration by staff. Resident to receive physical therapy from home health agency. Resident understands his current diagnosis and is well adjusted with it. Resident is wheelchair bound. Resident has follow-up appointments at [provider name] to inquire about treatment for his cancer. Resident is a diabetic and on anticoagulants. New orders faxed today. Will obtain vital signs and continue to monitor." On May 1, 2024, at 10:30 a.m. the surveyor	0 730			

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0 730	Continued From page 13 requested the nurse's notes from September 2023, through December 2023. On May 1, 2024, at 10:40 a.m. RN-B stated she had no further nurses' notes between September through R4's return to the facility in December and stated, "I don't have any notes to know why he [R4] went to the hospital in September." RN-B stated she would have expected the RN include at least a nurse's note entry regarding the provider appointment, any follow up plan and R4's trip to the emergency room. On May 1, 2024, at 1:15 p.m. R4 stated he had been a resident at the facility since last January (2023) and had some changes to his health starting in the fall but could not recall the exact dates. He stated he began having significant back pain sometime in September and had an appointment with his health care provider. X-rays were completed with that appointment and a referral was made for physical therapy for further support and therapies. R4 stated over the ensuing days the back pain had intensified and he was transported to a hospital in Rochester for further evaluation. During that hospitalization, it was revealed he had prostate cancer with metastases to the bone (spine) and a related vertebrae fracture and infection in the bone of one of his lower limbs. R4 stated he had procedures completed while hospitalized and then went to a skilled nursing facility for physical therapy and post hospital care. He stated he returned to the assisted living facility in late December. R4's [provider name] discharge summary dated December 7, 2023, indicated he was originally admitted to the hospital on September 18, 2023. His record indicated he was diagnosed with metastatic prostate cancer, with metastases to	0 730			

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0 730	Continued From page 14 his spine with a cancer related L3 lumbar fracture. He also had a surgical revision to his left lower limb amputation (November 2023). Furthermore, his record indicated he went to two skilled nursing facilities for follow up therapies and care until his return to the assisted living facility on December 19, 2023. On May 1, 2024, at 3:23 p.m. RN-B indicated the following: "Additional notes that I have located to help with timeline, this information was located in communication book as written by ULP: -September 12, 2023, Resident went to OMC for pain in his back -September 15, 2023 [home health agency name] was here to evaluate him for home health -September 19, 2023, Resident in pain and had a bm [bowel movement] on chair. Lethargic. Arranged for [transportation company name] transportation for a 9 am apt at Mayo Clinic. Resident was admitted." The licensee's RN failed to complete documentation of significant changes in R4's status starting late September regarding R4's back pain, provider's visit, and actions taken in response to the needs of the resident, including reporting to the appropriate health care professional, and lacked documentation of R4's need for transport to the hospital on September 18, 2023. R4's record lacked any follow up documentation/updates by the nurse until his return to the facility completed on December 19, 2023. The licensee's Resident Record policy dated August 1, 2021, indicated the licensee would include: - Documentation of significant changes in the	0 730			

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0 730	Continued From page 15 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; and - Documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional No further information provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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	0 800			

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0 800	Continued From page 16 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 30, 2024, at 10:00 a.m., survey staff toured the facility with director of facility operations (DFO)-I and maintenance technician (MT)-H. During the tour, survey staff observed the following: 1. The spring hinges installed on the labeled 20-minute fire doors leading from the corridor into resident dwelling units on the assisted living side were not working properly, these doors did not self-close and positively latch. This was observed for resident units 101, 102, 114, 117, 202, and 207. All components of a fire door assembly must be maintained in proper working order. During the facility tour interview on April 30, 2024, DFO-I verified the spring hinges were not working properly and stated the hinges would be adjusted. 2. In resident room 108, the labeled 20-minute fire door was propped open with a wedge. Fire doors held open by wedges prohibits the required operation and closing feature of the door. Additionally, there was a hole in the wall behind the door. During the facility tour interview on April 30, 2024, DFO-I verified the fire door was propped open and the hole in the wall. 3. A window blind was installed on the marked exit door in the assisted living dining room. Means of egress doors shall be easily recognizable as doors and not concealed by blinds. During the facility tour interview on April 30, 2024, DFO-I verified the window blind installation and stated this window blind would be removed. 4. Two electrical wall outlets were loose, one in	0 800			

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0 800	Continued From page 17 the assisted living dining room and one in the corridor next to resident room 222. During the facility tour interview on April 30, 2024, DFO-I and MT-H verified these electrical outlets were loose. 5. The exhaust fan did not work in the assisted living common-use bathroom. The exhaust fan cover was missing and the fan unit loose in the dementia care common-use bathroom. During the facility tour interview on April 30, 2024, DFO-I verified the condition of both exhaust fans and stated these exhaust fans required repair. 6. The cover was missing from the light fixture in the assisted living storage room near resident room 117. During the facility tour interview on April 30, 2024, DFO-I verified the light cover was missing. 7. Ceiling tiles were water-stained on and around the light fixture in the corridor near resident room 222. During the facility tour interview on April 30, 2024, MT-H verified the water-stained ceiling tiles. 8. Several pieces of exterior siding were missing near the trash area on the front side of the building. During the facility tour interview on April 30, 2024, DFO-I verified the missing siding and stated the siding needed to be reinstalled. 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; (2) employee actions to be taken in the event of	0 810			

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0 810	Continued From page 18 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, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide 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 19 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 April 30, 2024, the director of facility operations (DFO)-I provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP was not developed for the facility location and failed to include the following: The location and number of resident sleeping rooms were not accurately identified on the fire evacuation floor plans. On April 30, 2024, at 10:00 a.m., survey staff toured the facility with DFO-I and maintenance technician (MT)-H. During the tour, survey staff observed the numbers posted outside the resident rooms did not match the posted fire evacuation floor plans. Resident room numbers were not legible on the fire emergency floor plans posted in the facility. Additionally, resident rooms 207, 219, and 222 did not have numbers posted on the door. Accurate identification of all resident sleeping rooms is required to be included on the fire safety and evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee procedures were limited to determining if there was an actual fire and calling 911. The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing employees to evacuate	0 810			

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0 810	Continued From page 20 residents to the safest and nearest exit. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included an emergency evacuation report identifying which residents needed assistance, but the plan failed to include specific employee procedures for these residents. During an interview, on April 30, 2024, at 1:20 p.m. DFO-I verified the FSEP did not include the required information and would be revised. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident by the lack of training documentation to support this training had been completed. A fire drill report dated February 9, 2024, included the names of the residents who participated. No additional training documentation was provided. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. One employee training record dated April 25, 2024, was provided. This record did not include documentation to support employees had completed FSEP training on April 25, 2024. No additional training records were provided. During an interview, on April 30, 2024, at 1:20 p.m. DFO-I verified the training frequency was not met and stated no additional training records were available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a review of completed fire drill reports. In 2023, fire drills	0 810			

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0 810	Continued From page 21 were completed in April, August, September, October, November, and December. The time or shift of these drills was not recorded on the April, August, September, and October reports. No third shift fire drills were documented in 2023 and 2024. The evacuation drill frequency was not met. During an interview, on April 30, 2024, at 1:20 p.m. DFO-I verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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 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 provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, staff, and employees. This practice resulted in a level two violation (a	0 820			

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0 820	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 30, 2024, at 10:00 a.m., survey staff toured the secured dementia care unit with director of facility operations (DFO)-I and maintenance technician (MT)-H. During the tour, survey staff observed an illuminated exit sign posted above the door leading from the dining room to a patio enclosed by a fence. A key-only lock was installed on the exterior side of the fence gate. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. When locked exterior gates are installed as part of the egress path, these gates must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. During the tour interview on April 30, 2024, DFO-I verified the key only lock installed on the gate and stated this would be corrected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060			

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01060	Continued From page 23 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060			

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01060	Continued From page 24 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to assisted living with dementia care services on January 26, 2023. R4's Service Plan dated April 12, 2024, indicated he received the services of medication administration, blood sugar checks, safety checks, housekeeping and laundry. On April 30, 2024, at 11:37 a.m. the surveyor requested all nurse's notes for the previous six months for R4. The nurse's notes included the following entries: -December 14, 2023, by the licensee's licensed practical nurse (LPN)-"Resident will be returning to [facility name] on 12/19/23. Will await nurse to nurse report." -December 19, 2023, by the LPN-"Resident	01060			

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01060	Continued From page 25 returned to [facility name] today around 2:30 PM. Resident was admitted to [hospital name] 11/14/23 after L3 fracture from metastatic prostate cancer. Osteomyelitis was diagnosed on left stump. Resident went back to [hospital name] for revision of left stump on 11/27/23 and returned to [skilled nursing facility name] on 12/2/23. Resident stable at discharge today. Resident is independent with all ADL's and is pivot transfer only for all transfers and does so independently. Resident only has a prosthetic for his right lower extremity. Resident is non ambulatory. Full medication management by nursing and administration by staff. Resident to receive physical therapy from home health agency. Resident understands his current diagnosis and is well adjusted with it. Resident is wheelchair bound. Resident has follow-up appointments at [provider name] to inquire about treatment for his cancer. Resident is a diabetic and on anticoagulants. New orders faxed today. Will obtain vital signs and continue to monitor." R4's [provider name] discharge summary dated December 7, 2023, indicated he was originally admitted to the hospital on September 18, 2023. His record indicated he was diagnosed with metastatic prostate cancer, with metastases to his spine with a cancer related L3 lumbar fracture. He also had a surgical revision to his left lower limb amputation (November 2023). Furthermore, his record indicated he went to two skilled nursing facilities for follow up therapies and care until his return to the assisted living facility on December 19, 2023. On May 1, 2024, at 1:15 p.m. R4 stated he had been a resident at the facility since last January (2023) and had some changes to his health starting in the fall but could not recall exact dates.	01060			

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01060	Continued From page 26 He stated he began having significant back pain sometime in September and had an appointment with his health care provider. X-rays were completed with that appointment and a referral was made for physical therapy for further support and therapies. R4 stated over the ensuing days the back pain had intensified and he was transported to a hospital in Rochester for further evaluation. During that hospitalization, it was revealed he had prostate cancer with metastases to the bone (spine) and a related vertebrae fracture and infection in the bone of one of his lower limbs. R4 stated he had procedures completed while hospitalized and then went to a skilled nursing facility for physical therapy and post hospital care. He stated he returned to the assisted living facility in late December. R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - 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, R4's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned	01060			

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01060	Continued From page 27 to the facility within four days. On May 1, 2024, at 2:05 p.m. registered nurse (RN)-B stated the licensee had not completed an emergency relocation form, nor had they provided notification to the Ombudsman for R4's hospital and skilled nursing home stay that lasted longer than four days. The licensee's Emergency Relocation policy dated August 1, 2021, indicated: 1. In the event of an emergency relocation, [licensee name] will provide a written notice that contains, at minimum: a. The reason for the relocation b. The name and contact information for the location Lo which the resident has been relocated and any new service provider. c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected Lo return to the facility, or a statement that a return date is not currently known, e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 5. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided.	01060			

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01060	Continued From page 28	01060			
	TIME PERIOD TO CORRECT: Twenty-one (21) days.				
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01540			

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01540	Continued From page 29 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee had an provisional assisted living with dementia care license. ULP-F was hired on October 2, 2023, to provide direct care and services to the facility's residents. On April 30, 2024, at 6:36 a.m., the surveyor observed ULP-F check R1's blood sugar. ULP-F's employee record contained evidence the employee received seven and a half hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. On May 1, 2024, at 2:48 p.m., registered nurse (RN)-B stated ULP-F did not complete the required eight hours of dementia care training. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete eight hours of initial training withing 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620			

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01620	Continued From page 30 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment for a change in condition for one of one resident (R4); failed to complete proper falls assessments/follow up for two of two residents (R5, R2) and failed to conduct ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620			

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01620	Continued From page 31 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CHANGE IN CONDITION ASSESSMENT R4 R4 was admitted on January 26, 2023, with diagnoses including prostate cancer with metastases to the bone (spine), Type two diabetes (when the body no longer effectively manages blood sugar and insulin) with insulin dependence, diabetic retinopathy (diabetes affecting the eyes), acquired absence (amputation) of both lower extremities below the knee with prostheses, and chronic multifocal osteomyelitis (significant bone infections) R4's Service Plan dated April 12, 2024, indicated he received medication administration, blood sugar checks, safety checks, housekeeping and laundry. On April 30, 2024, at 11:00 a.m. unlicensed personnel (ULP)-E was observed to complete R4's lunch time blood sugar check and insulin administration. R4's record included a 90-day RN assessment dated September 4, 2023, when the RN indicated R4 did not have pain, had no record of falls, and no recent hospitalizations. On April 30, 2024, at 11:37 a.m. the surveyor	01620			

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01620	Continued From page 32 requested all nurse's notes for the previous six months for R4. The nurse's notes included the following entries: -December 14, 2023, by the licensee's licensed practical nurse (LPN)-"Resident will be returning to [facility name] on 12/19/23. Will await nurse to nurse report." -December 19, 2023, by the LPN-"Resident returned to [facility name] today around 2:30 PM. Resident was admitted to [hospital name] 11/14/23 after L3 fracture from metastatic prostate cancer. Osteomyelitis was diagnosed on left stump. Resident went back to [hospital name] for revision of left stump on 11/27/23 and returned to [skilled nursing facility name] on 12/2/23. Resident stable at discharge today. Resident is independent with all ADL's and is pivot transfer only for all transfers and does so independently. Resident only has a prosthetic for his right lower extremity. Resident is non ambulatory. Full medication management by nursing and administration by staff. Resident to receive physical therapy from home health agency. Resident understands his current diagnosis and is well adjusted with it. Resident is wheelchair bound. Resident has follow-up appointments at [provider name] to inquire about treatment for his cancer. Resident is a diabetic and on anticoagulants. New orders faxed today. Will obtain vital signs and continue to monitor." On May 1, 2024, at 10:30 a.m. the surveyor requested nurse's notes from September 2023, through December 2023. On May 1, 2024, at 10:40 a.m. RN-B stated she had no further nurses' notes between September through R4's return to the facility in December and stated, "I don't have any notes to know why he [R4] went to the hospital in September." RN-B stated she would have expected the RN to include at least a	01620			

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01620	Continued From page 33 nurse's note entry regarding the provider appointment, any follow up plan and R4's trip to the emergency room. On May 1, 2024, at 1:15 p.m. R4 stated he had been a resident at the facility since last January (2023) and had some changes to his health starting in the fall but could not recall exact dates. He stated he began having significant back pain sometime in September and had an appointment with his health care provider. X-rays were completed with that appointment and a referral was made for physical therapy for further support and therapies. R4 stated over the ensuing days the back pain had intensified and he was transported to a hospital in Rochester for further evaluation. During that hospitalization, it was revealed he had prostate cancer with metastases to the bone (spine) and a related vertebrae fracture and infection in the bone of one of his lower limbs. R4 stated he had procedures completed while hospitalized and then went to a skilled nursing facility for physical therapy and post hospital care. He stated he returned to the assisted living facility in late December. R4's [provider name] discharge summary dated December 7, 2023, indicated he was originally admitted to the hospital on September 18, 2023. His record indicated he was diagnosed with metastatic prostate cancer, with metastases to his spine with a cancer related L3 lumbar fracture. He also had a surgical revision to his left lower limb amputation (November 2023). Furthermore, his record indicated he went to two skilled nursing facilities for follow up therapies and care until his return to the assisted living facility on December 19, 2023. On May 1, 2024, at 3:23 p.m. RN-B indicated the	01620			

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01620	Continued From page 34 following information was located within the licensee's communication book: "Additional notes that I have located to help with timeline, this information was located in communication book as written by ULP: -September 12, 2023, Resident went to OMC for pain in his back -September 15, 2023 [home health agency name] was here to evaluate him for home health -September 19, 2023, Resident in pain and had a bm [bowel movement] on chair. Lethargic. Arranged for [transportation company name] transportation for a 9am apt at Mayo Clinic. Resident was admitted." The licensee's RN failed to complete documentation of significant changes or complete a comprehensive assessment related to R4's status regarding new and increasing back pain, provider's visit (September 12, 2023), and referral for physical therapy (September 15, 2023). On May 1, 2024, at 2:15 p.m. registered nurse (RN)-B indicated the licensee's RN had not completed an assessment for R4's change in condition related to his back pain, provider visit, and physical therapy referral. FALLS ASSESSMENTS R5 R5 was admitted on September 23, 2022, and his diagnoses included mild cognitive impairment. R5's Service Plan dated February 12, 2024, indicated he received medication administration, assistance with toileting, dressing, bathing, and safety checks. On May 1, 2024, at 10:35 a.m. ULP-K was observed interacting with R5 in his room as he	01620			

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01620	Continued From page 35 rested in his bed. R5's fall reports and record review indicated the following falls and findings: -January 12, 2024-fall with hip pain, no nurse follow-up, no noted interventions; -January 19, 2024, unwitnessed fall reported by resident- call to the On Call RN with report of hip pain rated at six out of ten; licensed practical nurse (LPN) followed up on January 24, 2024, with a nurse's note and indicated per report from the ULP, R5 could not recall how he fell; the follow up lacked a root cause and no interventions were implemented. The nurse follow up was five days after the fall; -February 12, 2024- On Call nurse's notes dated February 12, 2024, indicated a fall with hip pain; R5 sent to the emergency room (ER), X-Ray evaluation determined no hip fracture. No follow up from the RN following R5's return to the facility. No root cause/interventions implemented; -March 19, 2024-On Call nurse's note indicated a fall with cut to right elbow; nurse follow up occurred on April 2, 2024, with a nurse's note on April 3, 2024, with review of the fall, description of the right elbow cut, likely causative factors, and no new interventions needed; however, the post fall follow up occurred 14 days after the fall with injury; -April 14, 2024-On Call nurse note indicated R5 had an unwitnessed fall with complaints of a headache and received as needed (PRN) pain management; LPN follow up dated April 24, 2024, indicated root cause and interventions were updated; however, the follow up occurred 10 days following the fall and was not completed by a RN. -April 19, 2024- fall with pain to right shoulder, left neck pain, right elbow swollen/red/warm; director note entry on April 19, 2024, indicated notification to family and indicated emergency medical	01620			

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01620	Continued From page 36 services (EMS) cleared R5 and was not transported. Follow up by the licensee's LPN dated April 24, 2024, with similar root cause and interventions as written for April 14, 2024, fall follow up. Follow up was five days following a fall with injury and concerns with redness/warmth/swelling of right elbow. No evidence of an RN follow up or assessment. R5's record included the following RN Comprehensive Assessments with references to mobility/transfers/falls: -February 23, 2024-in section labeled Transfer-needs supervision to ensure safety when transferring- unsteadiness, requires one person assist PRN. In section labeled Mobility-needs occasional supervision- physical therapy (PT) consult requested; assistive device/walker requested. Missouri Alliance Health Care (MAHC-used as a falls assessment tool to predict a resident's risk for falls)- scored 8/10 with a note-PT ordered for consultation/treatment, assistive device/walker requested if deemed appropriate. Continue to monitor. -April 3, 2024- Transfer-can transfer without help, Walking- needs occasional supervision, requires PRN assistance by staff to remind resident to use walker, and wear well-fitting shoes while ambulating. MAHC- lacked a score and included the same verbiage as the assessment dated February 23, 2024, regarding PT consult requested, assistive device/walker requested, and continue to monitor. The licensee's RN failed to provide consistent and timely follow up regarding R5's multiple falls and failed to consistently review/ update/ implement interventions to minimize future falls. On May 1, 2024, at 10:15 a.m. RN-B stated with a	01620			

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01620	Continued From page 37 resident fall, the facility staff should contact the RN or on call RN if after hours, follow nursing instruction and complete a fall incident form. The expectation is within the next business day, the RN complete a face-to-face assessment, review causative factors, implement interventions to minimize future falls, and contact the resident's guardian and physician. RN-B stated the RN failed to or was inconsistent with her follow up to R5's falls and should have completed the required steps. FALLS ASSESSMENT R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. R2's unsigned, service plan dated April 24, 2024, indicated R2 received assistance with dressing, grooming, bathing, toileting reminders, housekeeping, laundry, safety checks, meal reminders, medication administration, blood glucose checks and daily weights. R2's individual abuse prevention plan (IAPP) dated February 5, 2024, indicated R2 had difficulty using the phone, was unable to activate call system and was at risk for falls. On April 30, 2024, at 6:50 a.m., the surveyor observed ULP-F place a gait belt on R2 and assist him with transferring out of his recliner to a standing position.	01620			

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01620	Continued From page 38 R2's fall reports and record review indicated the following falls and findings: -November 27, 2023, fall while transferring without his walker. On November 29, 2023, the RN documented the following root cause analysis: "Resident in Memory Care and is current enrolled in Hospice. Progressive Functional decline". The RN also documented the following actions taken to prevent future falls: "Reminded resident to use walker". -December 8, 2023, fall while transferring onto the toilet. R2's record lacked documentation of a nurse follow up or assessment to determine root cause analysis and/or actions to be taken to prevent future falls. -December 8, 2023, second fall in the bathroom while trying to pick up something from the floor. R2's record lacked documentation of a nurse follow up or assessment to determine root cause analysis and/or actions to be taken to prevent future falls. -December 26, 2023, unwitnessed fall near the entrance of his room. On December 28, 2023, the RN documented the following root cause analysis: "Resident in Memory Care and is current enrolled in Hospice. Progressive Functional decline". The RN also documented the following actions taken to prevent future falls: "Encouraged resident to ask for help and utilize his walker". -December 26, 2023, unwitnessed fall. On December 28, 2023, the RN documented the following root cause analysis "Resident in Memory Care and is current enrolled in Hospice. Progressive Functional decline". The RN also	01620			

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01620	Continued From page 39 documented the following actions taken to prevent future falls: "Encouraged resident to ask for help and utilize his walker". -February 10, 2024, unwitnessed fall. On February 23, 2024, the RN documented the following root cause analysis: "Resident found near bathroom. No noted injuries, Memory care resident on Hospice, has continued with functional decline". The RN also documented the following actions to be taken to prevent future falls: "Encouraged resident to ask for help and utilize his walker". -February 19, 2024, unwitnessed fall in another resident's bathroom. On February 26, 2024, the RN documented the following root cause analysis: "Resident most likely was trying to go to the bathroom or something. Not sure what resident was doing in another residents room or how he ended up on the floor. Resident that maybe fell was sitting on the floor actually sitting, and just scooching like that to get from point to point. He ended up in the other residents room by doing that. AL RA [Assisted Living Resident Assistant] helped to lift him up and support him with the walker and resident wanted to use the restroom so we ended up having to do it asap wherever. Resident seems okay now and is in his room and sitting in his chair. Unwitnessed resident was found by another resident and she called for help". The RN also documented the following actions to be taken to prevent future falls: "Encouraged resident to ask for assistance with transfers or ambulation especially at night. Also encouraged resident to use his walker with ambulation and the importance of wearing nonslip footwear for transfers ambulation". -February 20, 2024, unwitnessed fall. On	01620			

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01620	Continued From page 40 February 26, 2024, the RN documented the following root cause analysis "Not sure what resident was trying to do but he has been up mostly all night. Wandering the hallways and trying to get into other residents rooms. Was not staying still and tried multiple times to put into bed or on his couch. Resident was lying on his back and was already trying to get up". The RN also documented the following actions to be taken to prevent future falls: "Encouraged resident to ask for assistance with transfers or ambulation especially at night. Also encouraged resident to use his walker with ambulation and the importance of wearing nonslip footwear for transfers ambulation.." The licensee's RN failed to provide consistent and timely follow up regarding R2's multiple falls and failed to consistently review/update/implement interventions to minimize future falls. On May 1, 2024, at 10:45 a.m., RN-B stated her expectation was that the nurse would review each fall to determine root cause and to implement interventions to prevent future falls. ONGOING NURSING ASSESSMENT: R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. R1's service plan dated April 24, 2024, indicated R1 received assistance with grooming, bathing,	01620			

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01620	Continued From page 41 housekeeping, laundry, safety checks, medication administration and blood glucose checks. R1's ongoing nursing assessments were requested. Assessments dated November 20, 2023, February 23, 2024, and March 8, 2024, were provided. The February 23, 2024, assessment was done 95 days after the date of the previous assessment, exceeding 90 calendar days (five days late). On April 30, 2024, at 11:09 a.m., RN-B stated R1's February assessment exceeded 90 days from the previous assessment. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated resident monitoring and review would be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. The licensee's Falls policy dated February 1, 2022, indicated Post Fall Assessments will be completed by an RN after a fall if they remain at facility. RN to complete incident report timely and update care plan with intervention for fall prevention. The resident's practitioner (MD, NP, PA, etc) should be notified of any accidents/incidents involving the residents health, potential for injury, or other related concerns the practitioner should be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			

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01640	Continued From page 42	01640			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for two of three residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01640			

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NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972			
(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
01640	Continued From page 43 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. On April 30, 2024, at 6:06 a.m., the surveyor observed unlicensed personnel (ULP)-F place a gait belt on R1 to assist with transferring from the chair to a standing position. -at 8:35 a.m., ULP-F assisted resident in the bathroom with peri-care and putting on a pull up after he had a bowel movement. R1's service plan dated April 24, 2024, indicated R1 received assistance with grooming, bathing, housekeeping, laundry, safety checks, medication administration and blood glucose checks. The service plan did not include toileting or transfer services. R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. On April 30, 2024, at 6:50 a.m., the surveyor observed ULP-F place a gait belt on R2 and	01640			

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01640	Continued From page 44 assist him with transferring out of his recliner to a standing position. R2's service plan dated April 24, 2024, indicated R2 received assistance with dressing, grooming, bathing, toileting reminders, housekeeping, laundry, safety checks, meal reminders, medication administration, blood glucose checks and daily weights. The service plan did not include transfer services and was not signed by the R2 or R2's representative. On May 1, 2024, at 8:52 a.m., registered nurse (RN)-B stated all services provided to a resident should be listed on the resident's service plan. RN-B further stated if a ULP provided a service that was not on the service plan, the ULP was expected to document that service as an as needed service and update the nurse. RN-B stated the licensee had made multiple attempts to have R2's representative review and sign R2's service plan but had not been successful yet. The licensee's 6.10 Service Plan Modifications policy dated August 1, 2021, indicated when a resident received services and change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living	01690			

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01690	Continued From page 45 facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to implement it's policy regarding medication errors for one of three residents (R6). This practice resulted in a level two violation (a	01690			

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01690	Continued From page 46 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 29, 2024, at 10:25 a.m. during the entrance conference, registered nurse (RN)-B stated the licensee's procedure for follow up to medication errors was for the RN to review the error, contact the resident's provider, and follow up with the unlicensed personnel (ULP) regarding training to minimize future errors. R6 was admitted on November 29, 2023. R6's Service Plan dated January 31, 2024, indicated she received medication administration. R6's medication administration record (MAR) for January and February 2024, indicated she received one medication for cholesterol, one for allergies, three supplements, one antifungal, three for pain, one for constipation, one antifungal topical (on the skin), and one antibiotic (January). ULP-J had a hire date of November 6, 2023, and provided direct care services and medication administration to the residents of the facility. On April 29, 2024, at 2:45 p.m. the surveyor reviewed the licensee's medication errors from the previous six months. A pattern of medication errors was found with ULP-J about R6's medication administration and included the	01690			

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01690	Continued From page 47 following: -January 24, 2024 - the medication error report indicated ULP-J failed to administer Osteo-biflex (supplement). The medication error report indicated ULP-J administered one of the two tablets of the medication from the bubble pack. The error was found by the facility's licensed practical nurse (LPN) on February 15, 2024, while completing a medication cart audit. The following fields of the medication error report were left blank: notification of the emergency contact, notification of the physician, and action to prevent future errors. On January 24, 2024, at 6:29 p.m. ULP-J documented she administered Osteo-biflex two tablets orally. -January 31, 2024 - the medication error report indicated ULP-J failed to administer Osteo-biflex (supplement). ULP-J administered one of the two tablets of the medication from the bubble pack. The error was found by the facility's LPN on February 15, 2024, while completing a medication cart audit. The following fields of the medication error report were left blank: notification of the emergency contact, notification of the physician, and action to prevent future errors. On January 31, 2024, at 6:25 p.m. ULP-J documented she administered Osteo-biflex two tablets orally. -February 2, 2024 - the medication error report dated February 16, 2024, indicated ULP-J failed to administer vitamin D3 - 25 micrograms (mcg). The medication was found still in the bubble pack. On February 2, 2024, ULP-J documented she administered Vitamin D3 - 25 mcg, one tablet orally. The following fields of the medication error report were left blank: notification of the emergency contact, notification of the physician, and action to prevent future errors. R6's nurse's notes dated January 23, 2024, through February 27, 2024, were provided;	01690			

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01690	Continued From page 48 however, the licensee failed to include any documentation of the above listed medication errors. The licensee failed to follow the licensee's medication error policy related to the RN providing review of the medication errors, reporting to the prescriber/physician, or providing training to the ULP when errors occurred. On May 1, 2024, at 9:55 a.m. RN-B stated she expected the nurse to follow up on any known medication errors as soon as able, investigate the error and provide education to the ULP or staff who made the error. She stated she had no explanation as to why follow up to R6's medication errors had not occurred once discovered. The licensee's Medication Error policy dated August 1, 2021, indicated in the event an error occurs, staff will document, track, and resolve medication administration errors for quality improvement. Staff will be retrained if necessary. The licensed nurse will instruct the staff person on what to do next. This may include contacting the prescriber, family, and/or 911. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a	01730			

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01730	Continued From page 49 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	01730			

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01730	Continued From page 50 Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for two of three residents (R4, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4's diagnoses included prostate cancer with metastases to the bone (spine), Type two diabetes (when the body no longer effectively manages blood sugar and insulin) with insulin dependence, diabetic retinopathy (diabetes affecting the eyes), acquired absence (amputation) of both lower extremities below the knee with prostheses, and chronic multifocal osteomyelitis (significant bone infections). R4's Service Plan dated April 12, 2024, indicated he received assistance with medication administration. On April 30, 2024, at 11:00 a.m. unlicensed personnel (ULP)-E was observed to complete R4's lunch time blood sugar check and insulin administration. R4's Medication Administration Record (MAR) dated April 2024, indicated he received oral	01730			

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01730	Continued From page 51 medications to include one for prostate cancer, one for cholesterol, two for hypertension (high blood pressure), one for thyroid, one for heart rate/rhythm, two for constipation, one for mild pain and one for diarrhea. R4 also received two insulin injection medications, one eye drop medication for dry eyes, and one rectal medication for constipation. R4's Medication Management Plan dated April 5, 2024, indicated the delegated tasks for ULP included topical medication. The licensee failed to include the delegated tasks of oral, eye drops, rectal and injectable medications as relevant to R4. On May 1, 2024, at 1:15 p.m. registered nurse (RN)-B indicated R4's medication plan lacked the delegated tasks of oral, inhaled, and injectable medications. R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. R1's service plan dated April 24, 2024, indicated R1 received assistance with medication administration. On April 30, 2024, at 7:15 a.m., the surveyor observed ULP-F administer oral medications to R1. R1's MAR dated April 2024, indicated he received oral medications to include one for tremors, one	01730			

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01730	Continued From page 52 for diabetes, two for depression and anxiety, one for acid reflux, one for prostate, one for nausea, one for diarrhea, and four vitamins. R1 also received two insulin injection medications, one inhaler for nicotine withdrawal, one topical cream for dry skin and one topical gel for pain. R1's Medication Management plan dated March 29, 2024, lacked identification of medication management tasks that may be delegated to ULP. On May 1, 2024, at 10:48 a.m., RN-B stated R1's medication plan lacked identification of medication management tasks that may be delegated to the ULP. The licensee's Medication and Treatment Plan policy dated August 1,2021, indicated the plan would include: - identification of medication management tasks to be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01750			

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01750	Continued From page 53 each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure insulin via a prefilled insulin pen was administered according to manufacturer instructions by one of three unlicensed personnel (ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. R1's service plan dated April 24, 2024, indicated R1 received assistance with medication administration. R1's prescriber orders dated April 4, 2024, included Insulin Aspart 100 unit/milliliter (ml); inject 7 units under the skin three times a day	01750			

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01750	Continued From page 54 before meals and Insulin Glargine 100 units/ml; inject 18 units under the skin every night. On April 30, 2024, at 7:24 a.m., ULP-F obtained R1's insulin Aspart pen, removed the cap, then attached the needle to the port of the pen. ULP-F dialed the pen to the prescribed 7 units without priming the pen first. ULP-F did not cleanse the pen port with alcohol prior to attaching the needle to the pen. R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. R2's service plan dated April 24, 2024, indicated R2 received assistance with medication administration. R2's prescriber orders dated March 22, 2024, included Insulin Glargine Solostar 100 unit/ml; inject 26 units under the skin one time a day. On April 30, 2024, at 7:44 a.m., ULP-F obtained R2's Insulin Glargine Solostar pen, removed the cap, then attached the needle to the port of the pen. ULP-F dialed the pen to the prescribed 26 units without priming the pen first. ULP-F did not cleanse the pen port with alcohol prior to attaching the needle to the pen. On April 30, 2024, at 7:58 a.m., ULP-F stated she had not been trained to cleanse the insulin port with alcohol prior to attaching the needle and had not been trained to prime the insulin pen prior to dialing the prescribed dose.	01750			

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01750	Continued From page 55 On April 30, 2024, at 11:05 a.m., registered nurse (RN)-B stated the expectation with insulin administration via an insulin pen was that staff would cleanse the pen port with alcohol prior to attaching a new needle and then prime the pen with two units prior to dialing up the prescribed dose. The licensee's 5.12.02 Insulin Administration from a Pen policy, undated, indicated the insulin pen cap/port would be cleansed with a sterile alcohol wipe prior to attaching the new needle to the pen. It further indicated to prime the insulin pen by dialing up 2 units of insulin and waste the 2 units prior to dialing up the correct insulin dose. The manufacturer instructions for use for the insulin aspart revised February 2023, indicated the following: -Step A: Pull off the pen cap and wipe the rubber stopper with an alcohol swab. -Step B: Remove the protective tab from a disposable needle. Screw the needle tightly onto your pen. -Step C: Pull off the big outer needle cap. -Step D; Pull off the inner needle cap and throw it away -Step E: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure the proper dosing: Turn the dose selector to select two units -Step F: Hold your insulin pen with the needle point up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. -Step G: keep the needle point upwards, press the push-button all the way in. The dose selector returns to zero. -Step H: turn the dose selector to the number of	01750			

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01750	Continued From page 56 units you need to inject. The manufacturer instructions for use for the insulin Glargine Solostar pen dated 2022, indicated the following: -Step 1: Remove the pen cap with clean hands. Check the reservoir to make sure the insulin is clear and colorless and has no particles- if not, use another pen. -Step 2: wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle. Take off outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away. -Step 3: Dial a test dose of two units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890			

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NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972		
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01890	Continued From page 57 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of one resident (R10) and failed to ensure prescription medications were kept in the original container bearing the original prescription label 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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R10 R10's diagnoses included diabetes. R10's service plan dated April 24, 2024, indicated R10 received assistance with blood sugar checks and medication administration. On April 30, 2024, at 10:03 a.m., the surveyor observed the medication cart contents and verified with unlicensed personnel (ULP)-F. The surveyor noted there was no open date on R10's insulin glargine pen. ULP-F confirmed the insulin pen was not dated when opened, then checked the insulin level and stated the pen had been	01890			

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01890	Continued From page 58 used. On April 30, 2024, at 11:00 a.m., registered nurse (RN)-B stated insulin should be dated when opened. The manufacturer instructions for use for the insulin Glargine pen dated 2022, indicated after 28 days, throw your opened pen away- even if it still has insulin in it. PRESCRIPTION LABEL R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. R1's service plan dated April 24, 2024, indicated R1 received assistance with medication administration. On April 30, 2024, at 10:03 a.m., the surveyor observed the medication cart contents and verified with ULP-F. The surveyor noted a zip lock bag with R1's name written on it. The zip lock bag contained one tube of calcipotriene 0.005% gel without a label on it. On April 30, 2024, at 11:00 a.m., RN-B stated the calcipotriene gel was found in R1's room and placed in the medication cart. RN-B stated all medications should be kept in the original container bearing the original prescription label.	01890			

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01890	Continued From page 59 The licensee's Medications- Prescription Drugs and Prohibition policy dated August 1, 2021, indicated prescription drugs must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940			

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01940	Continued From page 60 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. R2's unsigned, service plan dated April 24, 2024, indicated R2 received assistance with daily	01940			

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01940	Continued From page 61 weights. R2's treatment record dated April 1, 2024, through April 30, 2024, indicated R2 received assistance with daily weights every morning. R2's treatment and therapy plan dated April 24, 2024, did not include daily weights. R2's record lacked physician orders for daily weights. On May 1, 2024, at 1:32 p.m., registered nurse (RN)-B stated daily weights was not listed on R2's treatment and therapy plan but should be since the service was being provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	01960			

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01960	Continued From page 62 Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted on April 21, 2023, with diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors) and diabetes. R1's physician orders dated April 4, 2024, included an order for medical compression stockings; follow as directed. R1's service plan dated April 24, 2024, indicated R1 received assistance with grooming, bathing, housekeeping, laundry, safety checks, medication administration and blood glucose checks. The service plan did not include compression stockings. R1's treatment and therapy plan dated April 24, 2024, did not include compression stockings.	01960			

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01960	Continued From page 63 R1's treatment record dated April 2024, did not include assistance with compression stockings. On May 1, 2024, at 1:32 p.m., registered nurse (RN)-B stated R1 does not have compression stockings and after reviewing R1's record, the order for compression stockings was never implemented. R2 R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. R2's unsigned, service plan dated April 24, 2024, indicated R2 received assistance with daily weights. R2's record lacked prescriber orders for daily weights. R2's treatment record dated April 1, 2024, through April 30, 2024, indicated R2 received assistance with daily weights every morning. However, the space to document the completion of the task on April 9, 11, 13, and 17, 2024, was left blank. R2's record lacked documentation of R2 declining his weight being taken or why the weights had not been taken or documented on the above dates. On May 1, 2024, at 8:55 a.m., RN-B stated R2's record lacked documentation of why his weight was not taken or documented on the above dates. RN-B further stated staff should document any refusal of services, or a reason why a service	01960			

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01960	Continued From page 64 was not provided. The licensee's 7.16 Medication and Treatment Orders-Implementing policy dated August 1, 2021, indicated upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. The licensee's Medication and Treatment Record- Documentation and Refusal policy dated August 1, 2021, indicated if a medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01970			

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01970	Continued From page 65 licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on October 20, 2023, with diagnoses that included vascular dementia (problems with reasoning, planning, judgement, memory, and other processes caused by brain damage from impaired blood flow to the brain) and diabetes. R2's unsigned, service plan dated April 24, 2024, indicated R2 received assistance with daily weights. R2's treatment record dated April 1, 2024, through April 30, 2024, indicated R2 received assistance with daily weights every morning. R2's record lacked physician orders for daily weights. On May 1, 2024, at 2:46 p.m., registered nurse (RN)-B stated R2's record lacked a physician's order for daily weights. The licensee's 7.20 Medication and Treatment	01970			

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01970	Continued From page 66 Orders policy dated August 1, 2021, indicated a current, written prescriber's order would be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all dementia care residents and staff. 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	02040			

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02040	Continued From page 67 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). Findings include: On April 30, 2024, the director of facility operations (DFO)-I provided an emergency preparedness binder with a hazard and vulnerability assessment tool completed as part of the emergency preparedness plan for natural, technological, and human hazards. An assessment of the physical environment identifying safety risks or hazards on and around the property with mitigation factors for an assisted living facility with a secured dementia care unit had not been completed. During an interview, on April 30, 2024, at 1:20 p.m. DFO-I verified a safety risk or hazard vulnerability assessment for the physical environment had not been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02310 SS=D	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:	02310			

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02310	Continued From page 68 Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of two residents (R9) with side rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R9 was admitted on April 2, 2023, with diagnoses that included hypertension (high blood pressure) and history of fractures. R9's service plan dated February 20, 2024, included the services of medication administration, daily weights, assistance with grooming, compression stockings, hearing aids, safety checks, and monthly vital signs. On April 30, 2024, at 6:25 a.m. unlicensed personnel (ULP)-G was observed to assist R9 with donning his compression stockings and obtain his weight. R9's room included a hospital bed with bilateral upper side rails. R9 stated the rails were used to assist him with repositioning while in bed. The side rails were securely fastened to R9's bed. R9's bed rail assessment dated April 23, 2024, included a review of the risks and benefits, and an assessment for R9's ability to use the side	02310			

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02310	Continued From page 69 rails properly. The assessment lacked completion with yes/no answers to: Side rails installed according to manufacturer's instructions, resident does not exceed side rails limit, and side rails attached securely to the bed. The assessment included a measurement of zone three (0.5 inches), but lacked measurements of zones one, two and four as required. Furthermore, the assessment included the following verbiage in the section below the statement that read Possible Interventions to be used instead of bedrails: "It was noted that this assistive device was installed improperly. In discussion with resident, she declines need. Staff indicate that she doesn't use the device." On April 30, 2024, at 10:12 a.m. registered nurse (RN)-B indicated R9 's side rail assessment was incomplete and included some inaccurate verbiage which appeared to have been copied from a (female) resident's side rail assessment. Furthermore, RN-B stated she didn't understand why the licensee completed bed rail measurements for zone three, but failed to complete measurements of zones one, two, and four as required. The licensee's Side Rails policy dated August 1, 2021, indicated the licensee will determine if the side rail is safe. "Safe" shall be defined as meeting all the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional	02310			

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NAME OF PROVIDER OR SUPPLIER ST CHARLES ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 402 WEST 4TH STREET SAINT CHARLES, MN 55972		
(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
02310	Continued From page 70 measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75". The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310			

Type: Full
Date: 04/30/24
Time: 08:41:25
Report: 1045241074

Food and Beverage Establishment Inspection Report

Page 1

Location:

St Charles Assisted Living
402 West 4th Street
St Charles, MN55972
Winona County, 85

Establishment Info:

ID #: 0032453
Risk: High
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

St Charles Assisted Living

Phone #: 5079324062
ID #: 46339

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.

5-200B Plumbing: cross connections

5-203.14A **** Priority 1 ****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

Water softener discharge hose in direct contact with floor drain cover leaving no air gap. Discussed options
Comply By: 04/30/24

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

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

Handles of scoops observed resting in direct contact with bulk dry goods (ie flour, sugar containers)
Comply By: 04/30/24

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit
Location: Mechanical Ware Wash
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Quat Spray Bottle
Violation Issued: No

Type: Full
Date: 04/30/24
Time: 08:41:25
Report: 1045241074
St Charles Assisted Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39F Degrees Fahrenheit - Location: Ref 1 - Deli Meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38F Degrees Fahrenheit - Location: Ref 2 - Produce
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37F Degrees Fahrenheit - Location: Ref 3 - Soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40F Degrees Fahrenheit - Location: MC Ref - beans
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167F Degrees Fahrenheit - Location: M. Potato
Violation Issued: No

Process/Item: Hot Holding
Temperature: 171F Degrees Fahrenheit - Location: Gravy
Violation Issued: No

Process/Item: Hot Holding
Temperature: 191F Degrees Fahrenheit - Location: Oven - Pork
Violation Issued: No

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

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

I acknowledge receipt of the MDH inspection report number 1045241074 of 04/30/24.

Certified Food Protection Manager Tracie Schaber

Certification Number: FM81523 Expires: 12/13/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Tracie Schaber
Kitchen Manager

Signed:  _____

Nicole Hunger
Public Health Sanitarian
Rochester District Office
nicole.hunger@state.mn.us

Report #: 1045241074

MDH
EH-FPLS
18 Wood Lake Dr
Rochester

DEPARTMENT
OF HEALTH

No. of RF/PHI Categories Out0

No. of Repeat RF/PHI Categories Out0

Legal Authority MN Rules Chapter 4626

Date04/30/24

Time In08:41:25

Time Out

St Charles Assisted Living

Address402 West 4th Street

City/StateSt Charles, MN

Zip Code55972

Telephone5079324062

License/Permit #
0032453

Permit Holder
St Charles Assisted Living

Purpose of Inspection
Full

Est Type

Risk Category
H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= repeat violation

Compliance StatusCOSR

Supervision

1INOUTPIC knowledgeable; duties & oversight

2INOUT N/ACertified food protection manager, duties

Employee Health

3INOUTMgmt/Staff;knowledge,responsibilities&reporting

4INOUTProper use of reporting, restriction & exclusion

5INOUTProcedures for responding to vomiting & diarrheal events

Good Hygenic Practices

6INOUT N/OProper eating, tasting, drinking, or tobacco use

7INOUT N/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8INOUT N/OHands clean & properly washed

9INOUT N/AN/ONo bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10INOUTAdequate handwashing sinks supplied/accessible

Approved Source

11INOUTFood obtained from approved source

12INOUT N/AN/OFood received at proper temperature

13INOUTFood in good condition, safe, & unadulterated

14INOUT N/AN/OREquired records available; shellstock tags, parasite destruction

Protection from Contamination

15INOUT N/AN/OFood separated and protected

16INOUT N/AFood contact surfaces: cleaned & sanitized

17INOUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance StatusCOSR

Time/Temperature Control for Safety

18INOUT N/AN/OProper cooking time & temperature

19INOUT N/AN/OProper reheating procedures for hot holding

20INOUT N/AN/OProper cooling time & temperature

21INOUT N/AN/OProper hot holding temperatures

22INOUT N/AFood in good condition, safe, & unadulterated

23INOUT N/AN/OProper date marking & disposition

24INOUT N/AN/OTime as a public health control: procedures & records

Consumer Advisory

25INOUT N/AConsumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26INOUT N/APasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27INOUT N/AFood additives: approved & properly used

28INOUTToxic substances properly identified, stored, & used

Conformance with Approved Procedures

29INOUT N/ACompliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in complianceMark "X" in appropriate box for COS and/or RCOS=corrected on-site during inspectionR= repeat violation

Compliance StatusCOSR

Safe Food and Water

30INOUT N/APasteurized eggs used where required

31Water & ice obtained from an approved source

32INOUT N/AVariance obtained for specialized processing methods

Food Temperature Control

33Proper cooling methods used; adequate equipment for temperature control

34INOUT N/AN/OPlant food properly cooked for hot holding

35INOUT N/AN/OFood in good condition, safe, & unadulterated

36Thermometers provided & accurate

Food Identification

37Food properly labeled; original container

Prevention of Food Contamination

38Insects, rodents, & animals not present

39Contamination prevented during food prep, storage & display

40Personal cleanliness

41Wiping cloths: properly used & stored

42Washing fruits & vegetables

Compliance StatusCOSR

Proper Use of Utensils

43XIn-use utensils: properly stored

44Utensils, equipment & linens: properly stored, dried, & handled

45Single-use/single service articles: properly stored & used

46Gloves used properly

Utensil Equipment and Vending

47Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48Warewashing facilities: installed, maintained, & used; test strips

49Non-food contact surfaces clean

Physical Facilities

50Hot & cold water available; adequate pressure

51XPlumbing installed; proper backflow devices

52Sewage & waste water properly disposed

53Toilet facilities: properly constructed, supplied, & cleaned

54Garbage & refuse properly disposed; facilities maintained

55Physical facilities installed, maintained, & clean

56Adequate ventilation & lighting; designated areas used

57Compliance with MCIAA

58Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)Date: 05/02/24

Inspector (Signature)