



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 30, 2025

Licensee
Elmore Assisted Living
202 East North Street
Elmore, MN 56027

RE: Project Number(s) SL31417016

Dear Licensee:

On April 4, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 9, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 9, 2025 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 9, 2025, found not corrected at the time of the April 4, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
2550-Restrictions Under Home And Community-Based W-144g.911 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 4, 2025 (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 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.

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 the Department of Health 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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/04/2025
NAME OF PROVIDER OR SUPPLIER ELMORE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST NORTH STREET ELMORE, MN 56027		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#31417016-1 On April 2, 2025, through April 4, 2025, 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 January 9, 2025. At the time of the survey, there were 46 residents; 46 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued: 0550, 0970, 2550.	{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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 550} SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced	{0 550}			

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{0 550}	Continued From page 3 by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the email contact information for the individuals responsible for handling resident grievances. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 2, 2025, at 9:20 a.m., the surveyor observed the grievance procedure posted on the wall outside the nurse's station door with housing manager (HM)-E. The procedure lacked the name, telephone number, and email contact information for the individual responsible for handling grievances. HM-E stated she knew the policy needed to be posted but was not aware of the required components. On April 2, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated the grievance procedure lacked the contact information for the individual responsible for handling the grievances. CNS-B indicated she was not aware of the requirement. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, noted the licensee would post in a conspicuous place, information	{0 550}			

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{0 550}	Continued From page 4 about the complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided.	{0 550}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	{0 810}			

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STATE FORM 6899 VL6012 If continuation sheet 6 of 15

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{0 970}	Continued From page 6 The licensee's undated, Master Assisted Living Resident Agreement (identified as the contract) included the following clause: -Page 20, section 30 of the contract indicated: Indemnification. As an occupant of the Facility, Resident assumes the risk for Resident's own safety and for the safety of Resident's personal property, guests and agents. Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with the loss of life, personal injury or damage to property, arising from or out of the use by Resident or Resident's guests of the Living Space or any other part of Facility, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. During the entrance conference on April 4, 2025, at 9:25 a.m., housing manager (HM)-E and clinical nurse supervisor (CNS)-B stated as part of their plan of correction the language as noted above had been removed from the contracts. However, CNS-B stated the licensee's lawyers had not approved the new contract yet, so none of the residents had received an updated contract yet. No further information was provided.	{0 970}			
{02550} SS=F	144G.911 RESTRICTIONS UNDER HOME AND COMMUNITY-BASED W The resident's rights in section 144G.91, subdivisions 12, 13, and 18, may be restricted for an individual resident only if determined necessary for health and safety reasons identified	{02550}			

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{02550}	Continued From page 7 by the facility through an initial assessment or reassessment under section 144G.70, subdivision 2, and documented in the written service plan under section 144G.70, subdivision 4. Any restrictions of those rights for people served under chapter 256S and section 256B.49 must be documented by the case manager in the resident's support plan, as defined in sections 256B.49, subdivision 15, and 256S.10. Nothing in this section affects other laws applicable to or prohibiting restrictions on the resident's rights in section 144G.91, subdivisions 12, 13, and 18. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have documented evidence for restricting rights as necessary for health and safety reasons by a case manager for three of three residents (R11, R18, R17) receiving assistance under community based waivers. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Master Assisted Living Resident Agreement included language on pages 13-14 titled Section 18.0 - Additional Resident Responsibilities. The Additional Resident Responsibilities section indicated 17 items that residents were required to follow and included: m. Not to consume alcohol or have open	{02550}			

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{02550}	Continued From page 8 containers of alcohol in resident's Living Space, common areas or elsewhere on the premises, or to all Resident's guest(s) to do so, unless approved by the Facility. R11 R11's Service Plan Agreement/Care Plan dated February 17, 2025, included: Alcohol use: Monitor- Resident has a history of alcohol/substance use and abuse, and relapsing. Resident eloped from previous facility to obtain substances and alcohol. If resident is exhibiting signs of impairment, staff are to notify nurse/hold meds/update medical provider. When resident is exhibiting signs of impairment: provide simple verbal prompts and make sure resident is as safe as possible. Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol. Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia may be removed and discarded properly by staff if seen in the open. Staff to follow medication administration record (MAR) if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility when left in the open and dispose of properly. Staff to notify nurse if this occurred. Smoking: Escort/Store Items- Assisted Living (AL) residents are able to smoke at all hours and memory care (MC) residents to smoke during their designated times of 9:30 a.m.-10:30 a.m., 12:20 p.m.-1:30 p.m., 3:30 p.m.-4:30 p.m., and 6:00 p.m.-7 p.m. All smoking materials will be kept at the nursing station for residents in the memory care unit.	{02550}			

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{02550}	Continued From page 9 R11's Safe Alcohol/Substance use Assessment Acknowledgment dated April 2, 2025, indicated R11 was aware they lived in a dry community. R11 had a past accident/incident and while under the influence left previous facility and got hypothermia. Nursing/Administration team recommends not to drink alcohol and would require 1:1 supervision while drinking alcohol/using substances. Resident and responsible party had been notified of the restrictions. R11's Safe Smoking Assessment/Acknowledgment dated March 21, 2025, indicated R11 was dependent on staff to light cigarette, and was dependent on staff to extinguish smoking materials into appropriate receptacle. R11 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R11's Coordinated Services and Support Plan (CSSP) dated March 1, 2024, indicated R11 lived in the memory care unit of the facility and received services including assistance with activities of daily living, medication management, meals, and transportation. R11's CSSP did not include any restrictions agreed upon with her case manager. R18 R18's Service Plan Agreement/Care Plan dated February 17, 2025, included: Alcohol use: Monitor- Resident is advised not to use alcohol due to medications and adverse effects. Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol. Team member to report to nurse or supervisor if	{02550}			

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{02550}	Continued From page 10 the resident appears unsteady or intoxicated. The licensee will do behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances/alcohol. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a recreational/controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia may be removed and discarded properly by staff if seen in the open. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility when left in the open and dispose of properly. Staff to notify the nurse if this occurred. Smoking: Escort/Store Items- AL residents are able to smoke at all hours and MC residents to smoke during their designated times of 9:30 a.m.-10:30 a.m., 12:20 p.m.-1:30 p.m., 3:30 p.m.-4:30 p.m., and 6:00 p.m.-7 p.m. All smoking materials will be kept at the nursing station for residents in the memory care unit. R18's Safe Alcohol/Substance use Assessment Acknowledgment dated March 21, 2025, indicated R18 was aware they lived in a dry community. R18 past accident/incidents will drink in excess with medication and will fall down risking severe injury. Nursing/Administration team recommends resident is unsafe to consume alcoholic beverages and would require 1:1 supervision while drinking alcohol/using substances. Resident and responsible party had been notified of the restrictions. R18's Safe Smoking Assessment/Acknowledgment dated March 21, 2025, indicated R18	{02550}			

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{02550}	Continued From page 11 was independent with lighting cigarette, but did not extinguish the cigarette appropriately or put in an appropriate receptacle. No past accidents/incidents with smoking materials. No burn marks on the resident's clothing. Nursing/Administration team recommendations is R18 will be supervised while smoking so staff are able to provide reminders to extinguish and dispose of cigarette properly. All smoking materials would be kept at the nurses' station, resident and responsible party notified of restrictions. R18's Support Plan from the Department of Human Services (DHS) dated August 1, 2024, indicated R18 received assistance from staff with grooming, bathing, medication management, transportation, meals, housekeeping, laundry, and behavior management. R18's plan indicated with personal care, staff would lay out his hairbrush, wash cloth, and oral care items each morning and evening for him to complete independently along with his shaver, but his belongings were locked back up after use. No other restrictions agreed upon with a case manager were noted in the plan. R17 R17's Service Plan Agreement/Care Plan dated February 17, 2025, included: Substance Use: Monitor- Resident is encouraged not to use substances while in facility due to meds and TBI (traumatic brain injury), staff to notify nurses if he is. The licensee will do behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances/alcohol. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a recreational/controlled substance. Educated by	{02550}			

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{02550}	Continued From page 12 staff we are drug and alcohol free facility and when an item of drug/alcohol/substance or paraphernalia may be removed and discarded properly by staff if seen in the open. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility when left in the open and dispose of properly. Staff to notify the nurse if this occurred. Alcohol Use: Monitor- Resident is encouraged to not drink while in facility due to meds and TBI, staff to notify nurses if he is drinking. Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol. Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The licensee will do behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances/alcohol. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a recreational/controlled substance. Educated by staff we are drug and alcohol free facility and when an item of drug/alcohol/substance or paraphernalia may be removed and discarded properly by staff if seen in the open. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility when left in the open and dispose of properly. Staff to notify the nurse if this occurred. Smoking: Escort Smoking Area- Resident is a 1:1 wile smoking at all times. Will be taken out together or separately than other residents. Accompany resident to smoking area. Report to nurse if unsafe to smoke. AL residents are able to smoke at all hours and MC residents to smoke during their designated times of 9:30 a.m.-10:30 a.m., 12:20 p.m.-1:30 p.m., 3:30 p.m.-4:30 p.m.,	{02550}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/04/2025
NAME OF PROVIDER OR SUPPLIER ELMORE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST NORTH STREET ELMORE, MN 56027			
(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
{02550}	Continued From page 13 and 6:00 p.m.-7 p.m. Smoking: Escort/Store Items- All smoking items will be stored in nurses' station and he will be able to get and count his items when he comes down at the posted smoking times. Retrieve tobacco product. Accompany resident to smoking area. Return tobacco products to storage. R17's Safe Alcohol/Substance use Assessment Acknowledgment dated April 2, 2025, indicated R17 was aware they lived in a dry community. R17 had a past accident/incident when he would be drinking and roaming the streets of Chicago, knocking on random people's doors asking for cigarettes and food. Nursing/Administration team recommends not to drink alcohol and would require 1:1 supervision while drinking alcohol/using substances. Resident and responsible party had been notified of the restrictions. R17's Safe Smoking Assessment/Acknowledgment dated April 2, 2025, indicated R17 was independent with lighting and extinguishing his smoking materials into an appropriate receptacle. No past accidents/incidents with smoking materials. No burn marks on the resident's clothing. Nursing/Administration team recommendations is to smoke on the 1:4 ratio at the posted times and when he can get out more often to take him out, but then he runs out of smokes and does not have any until he can go shopping again and this causes behaviors. R17's assessment further indicated he required supervision with smoking, all smoking materials would be kept at the nurses' station, resident and responsible party notified of restrictions. R17's CSSP dated May 1, 2024, indicated the	{02550}			

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{02550}	Continued From page 14 following: - Although R17 was only allowed three smoke breaks per day, his CSSP indicated "[R17] smokes quite often throughout the day (up to a pack a day)." - R17 was limited to 4 times a day phone usage; and - R17's services included bathing, dressing, grooming, managing behaviors, medication management, and meals. No further restrictions were in the CSSP, agreed upon with the case manager. On April 3, 2025, at 3:18 p.m., housing manager (HM)-E and clinical nurse supervisor (CNS)-B stated any restrictions noted in the service plan had been assessed and communicated to the resident's case worker. A request had been made for the case worker to update each resident's CSSP with the restrictions. HM-E and CNS-B indicated they had not received the CSSP back for any of the residents with restrictions yet, and likely wouldn't until their annual reviews were due by their case worker. No further information provided.	{02550}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 13, 2025

Licensee
Elmore Assisted Living
202 East North Street
Elmore, MN 56027

RE: Project Number(s) SL31417016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31417	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER ELMORE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST NORTH STREET ELMORE, MN 56027		
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0 000	Initial Comments 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: SL31417016-0 On January 6, 2025, through January 9, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 44 residents; 44 receiving services under the Assisted Living Facility 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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

Minnesota Department of Health

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;	0 500			

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0 500	Continued From page 4 (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 6, 2025, at 10:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B stated they were aware of the current minimum assisted living regulations and requirements of 144G.41. During the survey from January 6, 2025, through	0 500			

Minnesota Department of Health

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0 500	Continued From page 5 January 9, 2025, the surveyor completed observations, interviews, and record reviews for the licensee providing assisted living services to residents. The licensee failed to implement policies and procedures to address the following: - Refer to licensing order 0660 at MN Statute 144G.42. Subd. 9. The licensee failed to ensure a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test was completed according to protocol for one of two employees (unlicensed personnel (ULP)-F). - Refer to licensing order 1750 at MN Statute 144G.71 Subd. 7. The licensee failed to ensure delegated procedures were followed by four of four staff (ULP-G, ULP-H, ULP-I, ULP-F) observed during medication administration. - Refer to licensing order 1760 at MN Statute 144G.71 Subd. 8. The licensee failed to ensure medications were administered according to accepted standards of practice by four of four staff (ULP-G, ULP-H, ULP-I, ULP-F) observed during medication administration. - Refer to licensing order 1890 at MN Statute 144G.71 Subd. 20. The licensee failed to ensure medications were maintained bearing the original prescription label in all four of the facilities medication carts (MC1, MC2, MC3, MC4) and failed to ensure time sensitive medications were dated when open for two of seven residents (R5, R10) with insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 500			

Minnesota Department of Health

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0 500	Continued From page 6 (21) days	0 500			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 550			

Minnesota Department of Health

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0 550	Continued From page 7 portion or all of the residents). The findings include: The licensee failed to post the grievance procedure. During the facility tour on January 6, 2025, at 1:00 p.m., the surveyor observed the entry area, common areas, nurses' station, hallways, and dining area within the main floor of the facility and noted the grievance procedure was not posted. On January 6, 2025, at 1:05 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she thought the grievance procedure was posted by the nurses' station but was unable to locate it. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, included: 1. [The Licensee] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. 3. In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			

Minnesota Department of Health

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0 660	Continued From page 8	0 660			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (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	0 660			

Minnesota Department of Health

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0 660	Continued From page 9 only occasionally). The findings include: ULP-F was hired on October 16, 2024, to provide direct care to the residents of the facility. ULP-F's employee record identified she had completed delegated task competencies on October 18, 2024, and had a 30-day supervision completed on November 11, 2024, which indicated ULP-F had been providing delegated tasks during that time. ULP-F had a completed TB symptom screen dated October 6, 2024. ULP-F had a TST administered on December 27, 2024, and was read as negative on December 30, 2024. ULP-F's first step TST was not completed prior to providing care to the residents and she did not have a second step TST completed. On January 8, 2025, at 12:43 p.m., clinical nurse supervisor (CNS)-B stated ULP-F started at the facility completing her training, then went on vacation and was sick. ULP-F should have been given the first step when she was completing her competencies, and it should have been read prior to her working with the residents. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated new staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented.	0 660			

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0 660	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, develop an all-hazards	0 680			

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0 680	Continued From page 11 risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. In addition, the licensee failed to and evaluate its missing person policy at least quarterly as per Minnesota Rules Chapter 4659.0110 Subp. 4. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: POST AN EMERGENCY DISASTER PLAN PROMINENTLY During the facility tour on January 6, 2025, at 1:00 p.m., the surveyor observed there was no signage posted, or information regarding the licensee's emergency preparedness plan. On January 6, 2025, at 2:31 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the EP plan was kept at the nurses station and the plan was not posted within the facility. LALD/RN-A indicated she was not aware of the requirement. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's EP plan consisted of several documents and policies in a red three-ringed binder dated as reviewed July 16, 2024. The book included various policies/procedures related	0 680			

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0 680	Continued From page 12 to weather events, fire, missing person, and a bomb threat. The licensee lacked a customized EP plan to include the following required content: - Communication plan that includes contact information for the ombudsman, state licensing, and certification agencies. MISSING RESIDENT PLAN/POLICY The licensee's 2.28 Missing Resident policy dated August 1, 2021, was included in the EP plan. The policy lacked evidence the assisted living director and clinical nurse supervisor reviewed or updated the policy and documented any changes, at least quarterly as required. On January 9, 2024, at 12:07 p.m., LALD/RN-A stated the EP plan lacked the contact information as noted above. In addition, LALD/RN-A stated the missing resident policy had not been reviewed or updated quarterly as required. LALD/RN-A indicated she was not aware of the requirement. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, noted the facility would have an emergency preparedness plan that would include all required elements of appendix Z and align with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State	0 680			

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0 680	Continued From page 13 Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780			

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0 780	Continued From page 14 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on January 6, 2025, from 12:30 p.m. through 2:18 p.m., with housing manager (HM)-E, maintenance supervisor (MS)-C and executive chef (EC)-D, the surveyor observed the following: Carbon monoxide alarms were not provided outside of and within ten feet of resident sleeping rooms 103, 212, 203, 315, 309, 304, 306 and 301. MS-C stated that the alarms had been installed and was not sure why they were removed. State Fire Code in Minnesota Rules, chapter 7511 requires that carbon monoxide alarms be installed within ten feet of sleeping units.	0 780			

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0 780	Continued From page 15 In the East Wing laundry room, there was a vent disconnected from the back of the dryer. Dryer vents must be properly connected, maintained, and kept clear of obstruction to discharge heat and lint to the exterior and not create a fire hazard. MS-C stated they would reconnect the vent. Several items were stored at the bottom of the stairs in the West Wing. These items were blocking the exterior exit door that was part of an emergency evacuation route. Emergency evacuation routes must be free of obstructions, so they are available to use during a fire or similar emergency. MS-C stated the items would be relocated. The one hour rated fire door at the top of the stairs leading into the East Wing, by the nursing station, did not latch. The latch had been removed from the door jamb. Fire-resistant rated doors must automatically close and latch to prevent the spread of smoke and fire to adjoining building areas and floor levels. MS-C stated they would repair the latch. The surveyor observed an exterior door with an illuminated exit sign above it on the main floor by the West Wing laundry that led into a fenced yard. The surveyor exited the building through this door and observed a locked gate in the fence. When asked about the locked gate MS-C and HM-E stated the gate lock was not connected to the fire alarm system but staff was able to unlock it. The door was shown as an emergency exit on the post evacuation maps. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way.	0 780			

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0 780	Continued From page 16 HM-E, MS-C and EC-D verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not	0 810			

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0 810	Continued From page 17 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and failed to provide the required training. 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 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 January 6, 2025, at 2:20 p.m., housing manager (HM)-E 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 licensees FSEP titled "Fire Emergency", undated, failed to include the following: 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 plan included	0 810			

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0 810	Continued From page 18 the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility. The plan failed to include procedures for how staff are to complete each step. The FSEP included standard resident evacuation procedures but 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 instructions to evacuate residents but did not include any procedures for assisting residents during evacuation. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. HM-E stated residents were provided training during fire drills but was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. HM-E stated employees were provided annual training. Review of the documents provided showed one training provided in the past year. During an interview on January 6, 2025, at 3:30 p.m., HM-E stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

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0 810	Continued From page 19 (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Master Assisted Living Resident Agreement (identified as the contract) dated March 15, 2023, included the following clause: -Page 20, section 29 of the contract indicated: Indemnification. As an occupant of the Facility,	0 970			

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0 970	Continued From page 20 Resident assumes the risk for Resident's own safety and for the safety of Resident's personal property, guests and agents. Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with the loss of life, personal injury or damage to property, arising from or out of the use by Resident or Resident's guests of the Living Space or any other part of Facility, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents. On January 8, 2025, at 2:04 p.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed the licensee's current contract and stated it included the above content. LALD/RN-A stated an attorney had written the contract and she was not aware the language was not allowed. LALD/RN-A stated this contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:	01060			

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01060	Continued From page 21 (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 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 for one of one resident (R1).	01060			

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01060	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 began receiving assisted living services on March 15, 2023, with diagnoses of schizophrenia (mental disorder that affects how people think, feel, and behave), anxiety, and bipolar disorder (mental illness characterized by extreme mood swings). R1's Service Plan Agreement/Care Plan dated July 16, 2024, indicated R1 received assistance with bathing, dressing, grooming, transfers, ambulation, bed mobility, behaviors, catheter care, toileting, thickened liquids, and medication administration. R1's Progress Notes dated October 14, 2024, at 12:08 p.m., indicated R1 had went to a cardiology appointment and told the nurses that he was going to slit his own throat and that he had a plan to do so. He was sent to the emergency department and was admitted to inpatient for suicidal ideation with a plan to stab himself. R1's Progress Notes dated October 24, 2024, at 11:00 a.m. identified R1 had discharged from hospital and returned to the facility (10 days later). R1's record lacked a written notice that contained, at a minimum:	01060			

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01060	Continued From page 23 - 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, R1's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On January 8, 2025, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated nothing had been provided to the resident, legal representative, designated representative, or to the ombudsman. CNS-B stated she was not aware of the emergency relocation regulation. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, noted: 1. In the event of an emergency relocation, the licensee would provide a written notice that contains, at a minimum: a. The reason for the relocation; b. The name and contact information for the location to which the resident has been relocated and any new service provider; c. Contact information for the Office of Ombudsman for Long-Term Care;	01060			

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01060	Continued From page 24 d. 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; e. A statement that, if the facility refuses to provide housing or services after a relocation the resident has the right to appeal. 4. 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
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	01640			

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01640	Continued From page 25 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 revised to reflect the current services provided 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 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 began receiving assisted living services on March 15, 2023, with diagnoses of schizophrenia (mental disorder that affects how people think, feel, and behave), anxiety, and bipolar disorder (mental illness characterized by extreme mood swings). R1's Service Plan Agreement/Care Plan dated July 16, 2024, indicated R1 received assistance with compression stockings, bathing, dressing, grooming, transfers, ambulation, bed mobility, behaviors, catheter care, toileting, thickened	01640			

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01640	Continued From page 26 liquids, and medication administration. On January 7, 2025, at 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-G administer medications to R1. R1 was wearing regular black socks, not compression stockings. On January 8, 2025, at 8:22 a.m., ULP-J stated R1 did not wear compression stockings. On January 9, 2025, at 11:21 a.m., clinical nurse supervisor (CNS)-B stated R1's service plan had not been revised to reflect current services as his compression stockings had been discontinued. The licensee's 6.10 Service Plan Modifications policy dated August 2021, indicated when a resident receives assisted living services and a change 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			
01750 SS=E	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 27 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 delegated procedures were followed by four of four staff (unlicensed personnel (ULP)-G, ULP-H, ULP-I, ULP-F) observed during 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: R12 R12's diagnoses included diabetes. R12's Service Plan Agreement/Care Plan dated October 29, 2024, indicated R12 received services including medication administration. R12's prescriber orders dated August 20, 2024, included Humalog KwikPen (insulin lispro) (fast-acting insulin) 100 units/milliliter (ml), inject 10 units subcutaneously (under the skin) daily at noon.	01750			

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01750	Continued From page 28 On January 7, 2025, at 11:17 a.m., the surveyor observed ULP-G prepare R12's Humalog KwikPen, remove the cap, and secure a needle onto the hub of the KwikPen. ULP-G then dialed the KwikPen to one unit, held the pen horizontally, and pushed the pen button stating she was priming the pen. ULP-G did not use an alcohol swab to cleanse the hub of the KwikPen prior to applying a new needle, did not prime the pen by wasting two units after the new needle was applied, and did not hold the pen with the needle pointing up when priming. ULP-G stated the process she followed was how she was trained by the registered nurse (RN). R1 R1's diagnoses included diabetes. R1's Service Plan Agreement/Care Plan dated July 16, 2024, indicated R1 received services including medication administration. R1's prescriber orders dated April 30, 2024, included Humalog KwikPen 100 units/ml, inject 8 units subcutaneously three times a day before meals for premeal blood sugars greater than 180. On January 7, 2025, at 11:34 a.m., the surveyor observed ULP-G prepare R1's Humalog KwikPen, remove the cap, and secure a needle onto the hub of the KwikPen. ULP-G then dialed the KwikPen to one unit, held the pen horizontally, and pushed the button indicating she was priming the pen. ULP-G did not use an alcohol swab to cleanse the hub of the KwikPen prior to applying a new needle, did not prime the pen by wasting two units after the new needle was applied, and did not hold the pen with the needle pointing up when priming. ULP-G stated the process she followed was how she was trained by the RN.	01750			

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01750	Continued From page 29 R10 R10's diagnosis included diabetes. R10's service plan dated November 5, 2024, indicated R10's services included medication management and administration. R10's physician orders dated December 12, 2024, included Humalog 10 units three times a day with meals. R10's physician orders dated December 17, 2024, included Lantus inject 12 units in the a.m. R10's medication administration record dated January 1-7, 2025, included: - Humalog 10 units three times per day with meals; and - Lantus 12 units in the a.m. On January 7, 2024, at 7:30 a.m., the surveyor observed ULP-H administer insulin to R10. ULP-H removed the cap from the Humalog insulin pen. Opened the pen needle and placed it on the insulin pen. ULP-H turned the dose selector to 7 and stated that was all that was left in the pen so she would administer the 7 units and then would get a new pen to administer the remaining 3 units of his 10-unit dose. ULP-H cleaned R10's injection site and administered the insulin. ULP-H then removed the cap from the Lantus insulin pen, opened the pen needle and place it on the insulin pen. ULP-H dialed the dose selector to the appropriate dose, cleaned the injection site, administered the insulin and waited the appropriate time before removing the needle from the injection site. ULP-H did not use an alcohol swab to cleanse the hub of the Humalog or Lantus pens prior to applying a new needle	01750			

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01750	Continued From page 30 and did not prime the Humalog or Lantus pen by wasting two units. ULP-H returned to the medication cart where ULP-K had retrieved a new Humalog pen. ULP-K instructed ULP-H not to forget to prime the insulin pen. At 7:57 a.m., ULP-H returned to the resident room with the Humalog pen and ULP-K followed. ULP-H removed the pen cap, placed a new needle on the insulin pen, turned the dose selector to 2 units; while holding the insulin pen horizontally, ULP-H wasted the 2 units. ULP-K instructed ULP-H to prime the pen with the needle pointing up. ULP-H then turned the dial to 2 units and while pointing the pen up pushed the dose button. ULP-H then cleaned the injection site, administered the insulin and waited the appropriate time to remove the needle from the skin. ULP-H did not use an alcohol swab to cleanse the hub of the Humalog pen prior to applying a new needle. ULP-H stated she had been trained by a registered nurse on how to administer insulin. R7 R7's diagnoses included chronic pain, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe), fibromyalgia (a condition that causes pain in muscles and soft tissues all over the body), degenerative disk disease (a chronic condition that occurs when the discs in your spine wear down and break down) in the cervical (neck) and lumbar (lower back) region ,bipolar disorder (extreme mood swings that include emotional highs, called mania, and lows, known as depression), traumatic brain injury, and Parkinson's disease (a progressive movement disorder of the nervous system). R7's service plan dated July 16, 2024, indicated	01750			

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01750	Continued From page 31 R7 received medication management and administration. R7's MN Medication Treatment therapy Management plan dated July 16, 2024, indicated specific instructions for the medications were on the MAR. R7's physician orders dated April 30, 2024, included: - capsaicin 0.025% (topical pain cream) topically to affected areas three times daily for pain (did not include where to administer); - diclofenac sodium 1% (topical pain gel) apply 2 grams topically two times a day (did not include where to administer or indication for use); - fluticasone-salmeterol (reduces swelling in the airways and opens the bronchial tubes in the lungs) 500-50 micrograms (mcg) inhale 2 puffs by mouth two times a day; - Incruse Ellipta (helps the muscles around the airways in the lungs stay relaxed) 62.5 mcg inhale one puff into the lungs once daily; - fluticasone (reduces inflammation in the nose) 50 mcg spray inhale 2 sprays in each nostril daily; - tiotropium bromide (opens the airways of the lungs making it easier to breathe) inhale one capsule via handihaler once daily. R7's physician orders dated June 6, 2024, included Admelog (fast-acting insulin) 5 units subcutaneously three times a day before meals. R7's MAR dated January 1-7, 2024, included: - Admelog 5 units subcutaneously three times a day before meals; - capsaicin 0.025% cream topically to affected areas three times daily for pain (did not include where to administer); - diclofenac sodium 1% gel apply 2 grams	01750			

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01750	Continued From page 32 topically two times a day (did not include where to administer or indication for use); - fluticasone-salmeterol 500-50 mcg inhale 2 puffs by mouth two times a day; - Incruse Ellipta 62.5 mcg inhale one puff into the lungs once daily; - fluticasone 50 mcg spray inhale 2 sprays in each nostril daily; R7's MAR did not include the tiotropium bromide inhale one capsule via handihaler once daily; R7's MAR did not specify, in writing, specific instructions for R7's medications. On January 7, 2024, at 8:08 a.m., the surveyor observed ULP-I administering medications to R7. The following was observed: - ULP-I handed R7 her fluticasone solumeterol inhaler and R7 inhaled two puffs. ULP-I then immediately handed R7 her Incruse Ellipta inhaler and R7 inhaled one puff. R7 did not rinse her mouth after either inhaler and ULP-I did not give R7 water or instruct her to rinse her mouth. ULP-I did not wait 15 minutes between inhalers. - ULP-I then handed R7 her fluticasone nasal spray and R7 inhaled 3 sprays in the right nostril and 5 sprays in the left nostril instead of the ordered 2 sprays in each nostril. ULP-I did not assist in the administration and did not cue her to do 2 sprays. - ULP-I then picked up the diclofenac sodium gel, placed a small amount on her gloved hand and rubbed it on bilateral ankles stating that is where the diclofenac was to be administered for R7. ULP-I put the diclofenac gel back into the box and the measuring strip fell to the floor. ULP-I picked it up stating "it's just a little plastic thing" and placed it back in the box. ULP-I did not used the measuring strip to administer the correct dose of diclofenac. - ULP-I changed her gloves, removed R7's	01750			

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01750	Continued From page 33 Admelog insulin pen from a plastic box, removed the cap of the pen, and placed the needle on the pen. ULP-I then dialed the pen to 2 units and, with the needle facing downward, wasted the 2 units to prime the pen, turned the dose selector to the correct dose, cleaned the injections site, and injected the insulin waiting the appropriate time after injecting to remove the needle from the skin. ULP-I did not use an alcohol swab to cleanse the hub of the Admelog pen prior to applying a new needle and did not hold the the Admelog pen with the needle pointing upwards while priming the pen. ULP-I stated she had been trained by a registered nurse for medication administration. - ULP-I did not administer the capsaicin cream stating there was none in the medication cart. R6 R6's diagnoses included diabetes. R6's service plan dated July 17, 2024, identified R6's services included blood glucose monitoring, medication management and administration. R6's physician orders dated April 30, 2024, included Novolog inject 4 units subcutaneously three times a day. R6's MAR dated January 1-8, 2024, included Novolog inject 4 units subcutaneously three times a day. On January 7, 2024, at 8:35 a.m., the surveyor observed ULP-F check R6's blood glucose and administer insulin. ULP-F removed the Novolog insulin pen cap, placed a pen needle, primed the pen needle with 2 units while holding the insulin pen horizontally, and injected the insulin waiting the appropriate time after injecting to remove the needle from the skin. ULP-F did not use an	01750			

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01750	Continued From page 34 alcohol swab to cleanse the hub of the Novolog pen prior to applying a new needle and did not hold the Novolog pen with the needle pointing upwards while priming the pen. R8 R8's diagnoses included congestive heart failure, depression, knee pain, and degenerative disk disease in the lumbar and thoracic spine. R8's service plan dated July 17, 2024, indicated R8's services included medication management and administration. R8's physician orders dated April 30, 2024, included diclofenac gel apply 4 grams to right knee three times a day. R8's MAR dated January 1-7, 2024, included diclofenac gel apply 4 grams to the affected area three times a day. The MAR did not specify a location for the diclofenac gel. R8's MAR did not specify, in writing, specific instructions for R7's medications. On January 7, 2025, at 12:57 p.m., the surveyor observed ULP-F administer medication to R8. ULP-F put on gloves, administered oral medications, and asked R8 where she was having pain. R8 indicated her lower back. ULP-F put a small amount of diclofenac gel on her gloved hand and rubbed it on R8's lower back. ULP-F stated there was no way to measure the 4-gram dose as they did not have a scale. ULP-F stated she was trained to just put a small amount on. ULP-F stated R8's instructions for the diclofenac did not include location so she would ask R8 where she was having pain, and she would administer the gel there.	01750			

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01750	Continued From page 35 On January 8, 2024, at 12:43 p.m., clinical nurse supervisor (CNS)-B stated the staff should administer the diclofenac per the MAR. Staff should measure the quantity with the measuring strip provided by the manufacturer. If the MAR directs to apply to the affected area, staff were to ask the resident where they want it applied and they should apply it to that location. CNS-B was unaware R8's orders said to apply diclofenac to the knees; however, CNS-B stated if that is how it was ordered then staff should administer it there. On January 8, 2024, at 12:54 p.m. CNS-B stated when administering insulin, staff were to put the needle on the insulin pen, hold the insulin pen horizontally while priming the pen with 2 units, dial the dose, clean the injection site and then administer and hold for ten seconds. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of medications is delegated to unlicensed personnel the facility will ensure the nurse has; 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident. Humalog KwikPen instructions for use dated revised March 31, 2020, noted: Step 7: To prime your Pen, turn the Dose Knob to select 2 units.	01750			

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01750	Continued From page 36 Step 8: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 9: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. Lantus step-by-step guide to using your pen dated 2022, noted: Step 2: wipe the pen tip (rubber seal) with an alcohol swab. Removed the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Step 3: Dial a test dose of 2 units. Hold the 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. The Admelog SoloStar Instructions for Use dated revised November 2019 noted: 1D. Wipe the rubber seal with an alcohol swab. 2. Attach a new needle The NovoLog injection FlexPen Instructions for Use dated revised February 2023, noted: A. Pull off the pen cap, wipe the rubber stopper with an alcohol swab. B. Attach the needle E. Turn the dose selector to select 2 units F: Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the	01750			

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01750	Continued From page 37 push-button all the way in. The dose selector returns to 0. The Voltaren (diclofenac) gel instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 2-gram line (a 2.25-inch length of gel) or 4-gram line (a 4.5 inch length of gel). Make sure that the gel covers the 2-gram or 4-gram area of the doing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use. The How to Use fluticasone propionate and salmeterol inhalation powder instructions dated revised January 2020, identified: Step 5: Rinse your mouth. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760			

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01760	Continued From page 38 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to accepted standards of practice by four of four employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I, ULP-F) observed during 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: R12's diagnoses included schizophrenia (mental disorder that affects how people think, feel, and behave), anxiety, and bipolar disorder (mental illness characterized by extreme mood swings). R12's Service Plan Agreement/Care Plan dated October 29, 2024, indicated R12 received services including medication administration. R12's prescriber orders dated April 30, 2024,	01760			

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01760	Continued From page 39 included an order for diclofenac sodium 1% gel (topical nonsteroidal anti-inflammatory drug). Apply 2 grams to affected areas four times daily to areas causing pain. R12's medication administration record (MAR) dated January 1, 2025, through January 7, 2025, included diclofenac sodium 1% gel, apply 2 grams to affected areas causing pain four times daily. On January 7, 2024, at 11:17 a.m. the surveyor observed ULP-G prepare and administer medications to R12. ULP-G reviewed R12's MAR, sanitized hands, donned clean gloves, and placed a pea sized amount of R12's diclofenac sodium 1% gel to her gloved hand. ULP-G applied the gel to R12's bilateral shoulders and hips. ULP-G did not measure the amount of diclofenac gel applied. Following the application of the gel, ULP-G removed gloves, sanitized hands, and documented the diclofenac sodium 1% gel administration. When interviewed at this time, ULP-G stated she did not have a good answer for how to measure 2 grams as ordered. ULP-G stated she was unaware of the measuring device to be utilized when measuring the amount of gel to administer. In addition, ULP-G stated the order did not identify locations to apply the gel, but stated R12 liked it on his bilateral shoulders and hips. ULP-G administered the diclofenac gel incorrectly. R9 R9's diagnoses included traumatic brain injury, and schizophrenia. R9's physician orders dated April 30, 2024, included gabapentin 100 mg, take three times a day with meals.	01760			

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01760	Continued From page 40 R9's MAR dated January 1-8, 2025, identified gabapentin 100 mg three times a day scheduled at 8 a.m., 2 p.m., and 8 p.m. On January 6, 2025, at 1:33 p.m., the surveyor observed ULP-H administer gabapentin (anticonvulsant) 100 mg by mouth to R9. The gabapentin was not administered with meals as ordered. R7 R7's diagnoses included chronic pain, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe), fibromyalgia (a condition that causes pain in muscles and soft tissues all over the body), degenerative disk disease (a chronic condition that occurs when the discs in your spine wear down and break down) in the cervical (neck) and lumbar (lower back) region, bipolar disorder (extreme mood swings that include emotional highs, called mania, and lows, known as depression), traumatic brain injury, and Parkinson's disease (a progressive movement disorder of the nervous system). R7's physician orders dated April 30, 2024, included: - capsaicin 0.025% cream topically to affected areas three times daily for pain (did not include where to administer) - diclofenac sodium 1% gel apply 2 grams topically two times a day (did not include where to administer or indication for use) - fluticasone-salmeterol 500-50 micrograms (mcg) inhale 2 puffs by mouth two times a day. - Incruse Ellipta 62.5 mcg inhale one puff into the lungs once daily.	01760			

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01760	Continued From page 41 - fluticasone 50 mcg spray inhale 2 sprays in each nostril daily - tiotropium bromide inhale one capsule via handihaler once daily R7's physician orders dated June 6, 2024, included Admelog 5 unit subcutaneously three times a day before meals. R7's MAR dated January 1-7, 2024, included: - Admelog 5 units subcutaneously three times a day before meals - capsaicin 0.025% cream topically to affected areas three times daily for pain (did not include where to administer) - diclofenac sodium 1% gel apply 2 grams topically two times a day (did not include where to administer or indication for use) - fluticasone-salmeterol 500-50 mcg inhale 2 puffs by mouth two times a day. - Incruse Ellipta 62.5 mcg inhale one puff into the lungs once daily. - fluticasone 50 mcg spray inhale 2 sprays in each nostril daily R7's MAR did not include the tiotropium bromide inhale one capsule via handihaler once daily. R7's MAR did not specify, in writing, specific instructions for R7's medications. On January 7, 2024, at 8:08 a.m., the surveyor observed ULP-I administer medications to R7, to include the following: - ULP-I handed R7 her fluticasone solumeterol (reduces swelling in the airways and opens the bronchial tubes in the lungs) inhaler and R7 inhaled two puffs. ULP-I then immediately handed R7 her Incruse Ellipta (helps the muscles around the airways in the lungs stay relaxed) inhaler and R7 inhaled one puff. R7 did not rinse her mouth after either inhaler and ULP-I did not give R7 water or instruct her to rinse her mouth. ULP-I did	01760			

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01760	Continued From page 42 not wait 15 minutes between inhalers. - ULP-I then handed R7 her fluticasone (reduces inflammation in the nose) nasal spray and R7 inhaled 3 sprays in the right nostril and 5 sprays in the left nostril instead of the ordered 2 sprays in each nostril. ULP-I did not assist in the administration and did not cue her to do 2 sprays. - ULP-I then picked up the diclofenac sodium gel, placed a small amount on her gloved hand and rubbed it on bilateral ankles stating that is where the diclofenac was to be administered for R7. ULP-I did not ask R7 where she would like the diclofenac. ULP-I put the diclofenac gel back into the box and the measuring strip fell to the floor. ULP-I picked it up stating "it's just a little plastic thing" and placed it back in the box. ULP-I did not use the measuring strip to administer the correct dose of diclofenac. - ULP-I changed her gloves, removed R7's Admelog (fast-acting insulin) pen from a plastic box, removed the cap of the pen, and placed the needle on the pen. ULP-I then dialed the pen to 2 units and, with the needle facing downward, wasted the 2 units to prime the pen, turned the dose selector to the correct dose, cleaned the injections site, and injected the insulin waiting the appropriate time after injecting to remove the needle from the skin. ULP-I did not use an alcohol swab to cleanse the hub of the Admelog pen prior to applying a new needle and did not hold the the Admelog pen with the needle pointing upwards while priming the pen. ULP-I stated she had been trained by a registered nurse for medication administration. - ULP-I did not administer the capsaicin (topical pain cream) stating there was none in the medication cart. On January 8, 2024, at 1:04 p.m., clinical nurse supervisor (CNS)-B stated staff should have	01760			

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01760	Continued From page 43 administered one of R7's inhalers and waited 15 minutes before administering the second inhaler and staff should have had R7 rinse her mouth after administering the inhalers. On R7's MAR it is for staff to administer the nasal spray and inhalers but R7 can self-administer. CNS-B further stated staff should have redirected R7 when she administered too many sprays of the nasal spray and then they should have notified the nurse. R7's diclofenac is ordered for affected areas and her most affected area is her lower back. R8 R8's diagnoses included congestive heart failure, depression, knee pain, and degenerative disk disease in the lumbar and thoracic spine. R8's physician orders dated April 30, 2024, included diclofenac gel apply 4 grams to right knee three times a day. R8's MAR dated January 1-7, 2024, included diclofenac gel apply 4 grams to the affected area three times a day. The MAR did not specify a location for the diclofenac gel. On January 7, 2025, at 12:57 p.m., the surveyor observed ULP-F administer medications to R8. ULP-F put on gloves, administered oral medications, and asked R8 where she was having pain. R8 indicated her lower back. ULP-F put a small amount of diclofenac gel on her gloved hand and rubbed it on R8's lower back. ULP-F stated there was no way to measure the 4-gram dose as they did not have a scale. ULP-F stated she was trained to just put a small amount on. ULP-F stated R8's instructions for the diclofenac did not include location so she would ask R8 where she was having pain, and she	01760			

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01760	Continued From page 44 would administer the gel there. On January 8, 2024, at 12:43 p.m., CNS-B stated the staff should administer the diclofenac per the MAR. Staff should measure the quantity with the measuring strip provided by the manufacturer. If the MAR indicates to apply to the affected area, staff are to ask the resident where they want it applied and they should apply it to that location. CNS-B was unaware R8's orders said to apply diclofenac to the right knee; however, CNS-B stated if that is how it was ordered then staff should administer it there. CNS-B stated the gabapentin times should have been administered with meals as ordered and the MAR was incorrect. The diclofenac sodium instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 2 G line (a 2.25-inch length of gel). Make sure that the gel covers the 2 G area of the doing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when administration of medications is delegated to unlicensed personnel the facility will ensure the nurse has; 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for	01760			

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01760	Continued From page 45 each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label in all four of the facility's medication carts (MC2, MC3, MC1, MC4) and failed to ensure time sensitive medications were dated when open for two of seven residents (R5, R10) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01890			

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01890	Continued From page 46 The findings include: On January 6, 2024, at 1:43 p.m., the surveyor reviewed MC2 with unlicensed personnel (ULP)-H and identified the following: - a plastic container containing R5's name included: - a Humalog insulin pen which had a piece of fabric medical tape covering the manufacturer label, making the label very difficult to read, with "12/25" written on the tape. The insulin pen did not have a pharmacy label. - a Lantus insulin pen with no pharmacy label and no open date was noted on the pen. The insulin pen did not contain an opened date, making it difficult to know when it should be used by. - a plastic container containing R10's first name and initial of his last name included: - a Lantus insulin pen with no pharmacy label and no open date was noted on the pen. The insulin pen did not contain an opened date, making it difficult to know when it should be used by. - a Humalog insulin pen with tape covering the manufacturer label, making the label hard to read, with "12/29 on the paper tape. The insulin pen did not contain a pharmacy label. On January 6, 2024, at 2:00 p.m. the surveyor reviewed MC3 with ULP-I and identified the following: - a plastic container labeled "MM", staff identified as R7, included: - a basaglar insulin pen without a pharmacy label - a Admelog insulin pen without a pharmacy label - a plastic container containing R13's first name	01890			

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01890	Continued From page 47 and initial of the last name included: - a Lantus insulin pen without a pharmacy label - a plastic container labeled with R14's name included: - fluticasone inhaler without a pharmacy label. Staff identified a box in the medication cart that was for the inhaler which contained a pharmacy label; however, the inhaler was stored separately from the labeled box. - a plastic container labeled with R7's name included: - a ventolin inhaler with a small pharmacy label which did not include the name and strength of the medication or the directions for use. - two bottles of nystatin powder with a small pharmacy label which did not include the name and strength of the medication or the directions for use. On January 6, 2025, at 2:02 p.m., the surveyor observed MC1 with ULP-G and identified the following: - a plastic pencil box with R1's name included: - a Lantus SoloStar insulin pen without a pharmacy label. - a plastic pencil box with R12's name included: - lispro kwikpen insulin without a pharmacy label - a Lantus SoloStar insulin pen without a pharmacy label. ULP-G indicated the unlabeled insulin pens were for each resident identified by plastic pencil box but was unable to verify without a label attached to the medication. On January 6, 2024, at 2:30 p.m., the surveyor observed MC4 with ULP-F and identified the following: - a plastic container labeled with R6's name	01890			

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01890	Continued From page 48 included: - aspart insulin pen with tape covering the manufacturer label, making the label hard to read, with "12/25" on the paper tape. The insulin pen did not contain a pharmacy label. - a Lantus insulin pen with without a pharmacy label. On January 6, 2024, at 2:45 p.m., CNS-B stated the pharmacy does not label the insulin pens individually and the medications that had the small pharmacy labels without the full prescribing information were sent from the pharmacy with the partial label. Lantus prescribing information dated June 2023, identified "Only use your pen for up to 28 days after its first use. Throw away the Insulin Glargine SoloStar pen you are using after 28 days, even if it still has insulin left in it. " The licensee's 7.13 Medications- Prescription Drugs & Prohibition policy dated August 1, 2021, noted when the licensee receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored according to manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890			

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01890	Continued From page 49 days	01890			
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 interview and record review, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	02040			

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02040	Continued From page 50 On January 6, 2025, at 2:20 p.m., housing manager (HM)-E provided documents on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview on January 6, 2025, at 3:30 p.m., HM-E verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			
02130 SS=F	144G.83 Subd. 2 Staffing requirements (a) The licensee must ensure that staff who provide support to residents with dementia can demonstrate a basic understanding and ability to apply dementia training to the residents' emotional and unique health care needs using person-centered planning delivery. Direct care dementia-trained staff and other staff must be trained on the topics identified during the expedited rulemaking process. These requirements are in addition to the licensing requirements for training. (b) Failure to comply with paragraph (a) or subdivision 1 shall result in a fine under section 144G.31. This MN Requirement is not met as evidenced by: The facility failed to ensure staff trained in	02130			

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02130	Continued From page 51 dementia care provided person centered care to residents residing in memory care when they required all residents be treated the same with the same restrictions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Drug and alcohol-free facility R16 On January 9, 2024, at 12:46 p.m., R16 stated the licensee did not allow drinking; it was "against the law" at the facility. R16 further stated she was not able to come and go as she would like; she was only allowed to leave the facility for outings and the smoke breaks three times a day. In addition, R16 may shower/groom independently, but R16's personal care items must be locked up between each use because of residing in a memory care unit. R16 stated her guardian had asked for increased privileges in the past and the facility said no. R16 stated her guardian handles her finances, but she was frustrated she was not able to go outside when she wanted. R16's unsigned, Service Plan Agreement printed January 9, 2025, indicated "Provide behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled	02130			

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02130	Continued From page 52 substances. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff." Staff are to "remove all alcohol and substances from the facility and dispose of properly" and notify the registered nurse. R15 On January 9, 2025, at 1:45 p.m., R15 used expletive language, expressing frustration with being unable to have any alcohol or to come and go freely. R15's unsigned, Service Plan Agreement printed on January 9, 2024, indicated R15 has a history (Hx) of alcohol abuse, staff to monitor and notify nurse of any changes. Provide behavioral monitoring assure the resident is safe if choosing to drink alcohol. Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The community to provide a safe environment if the Resident chooses to consume alcohol. The community cannot take responsibility if the resident chooses to consume alcoholic substances. R15's individual abuse prevention plan (IAPP) dated July 15, 2024, included "Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility and dispose of properly" and notify the nurse.	02130			

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02130	Continued From page 53 R11 On January 9, 2025, at 12:30 p.m., R11 stated she was only allowed to go out to smoke three times per day. R11's unsigned, Service Plan Agreement printed January 8, 2025, indicated alcohol use - "Resident has a history of alcohol/substance use and abuse, and relapsing. Resident eloped from previous facility to obtain substances and alcohol." "If resident is exhibiting signs of impairment, staff are to notify nurse/hold meds/update medical provider." "When resident is exhibiting signs of impairment: provide simple verbal prompts and make sure resident is as safe as possible." "Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol." "Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The community to provide a safe environment if the Resident chooses to consume alcohol. The community cannot take responsibility if the resident chooses to consume alcoholic substances." R11's IAPP dated April 5, 2024, indicated "Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility and dispose of properly" and notify the nurse. R18 R18's Service Plan Agreement signed by R18's guardian on July 16, 2024, included substance	02130			

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02130	Continued From page 54 use - monitor resident for substance use, report any unusual behaviors to the facially nurse, history of alcohol and OTC medications. Provide behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff the we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded property by staff." "Staff to remove all alcohol and substances from the facially and dispose of properly. Staff to notify the nurse If this occurred. The community to provide a safe environment if the resident chooses to use a recreational substance. The community cannot take responsibility if the resident chooses to use recreational/controlled substances." The licensee's Master Assisted Living Resident Agreement included language on pages 13-14 titled Section 18.0 - Additional Resident Responsibilities. The Additional Resident Responsibilities section indicated 17 items that residents were required to follow and included: m. Not to consume alcohol or have open containers of alcohol in resident's Living Space, common areas or elsewhere on the premises, or to all Resident's guest(s) to do so, unless approved by the Facility On January 8, 2025, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated the facility was drug and alcohol free so if they have alcohol in a public area, it is taken away and disposed of. Some of the residents had drug and alcohol problems in the past and should not have it around them. If they were to drink at the facility and be drunk and unmanageable, they would have to call the police	02130			

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02130	Continued From page 55 which would put a strain on emergency services. Therefore, the facility was a drug and alcohol free facility and all residents were to adhere to that. On January 9, 2025, at 3:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B stated the licensee was a drug and alcohol-free facility and the same resident agreement was utilized for all residents. CNS-B further stated the rule applied to all residents and if alcohol was found, it would be removed and disposed of. The residents signed and agreed to this in their service plans. [R18] has gone out with a friend, drank alcohol, smoked marijuana and returned to the facility; however, if he returned to the facility with the alcohol or marijuana, the facility would take it and dispose of it. Smoking On January 6, 2025, at 11:20 a.m., the surveyor observed R17, walking around asking different staff members if he could smoke and what the temperature was outside. The staff were informing him it was too cold to smoke. On January 6, 2025, at 1:15 p.m., housing manager (HM)-E stated the facility had taken away smoking for all memory care residents due to the cold temperature. On January 6, 2025, at 1:28 p.m., unlicensed personnel (ULP)-H stated smoking was canceled for all residents residing in memory care. R17 does not remember that smoking is canceled, so he continues to ask staff to go out and what the temperature is. On January 7, 2025, at 7:54 a.m. the surveyor	02130			

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02130	Continued From page 56 observed R17 witting near the entrance of the unit in a winter jacket and stocking cap. ULP-H stated the residents were already waiting to smoke, even though the smoke break was not until 10:00 a.m. On January 7, 2025, at approximately 10:00 a.m., the surveyor observed a document posted on the memory care door which read, "memory care smoke breaks are from: 10-11 am, 2-3 pm, 6-7 pm assisted living resident are NOT allowed in the courtyard for these 3 hours a day. Please plan your day as you will not be allowed to "sneak through" when they are outside. Thanks." R11 On January 9, 2025, at 12:30 p.m., R11 stated she was only allowed to go out to smoke three times per day. R11's unsigned, Service Plan Agreement printed January 8, 2025, did not include smoking assistance. R11's IAPP dated April 5, 2024, included R11's smoking assessment. Although, the smoking assessment indicated R11 was able to get to the smoking area independently, could light cigarette safely, dispose of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials; R11 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. R11 and responsible party had been notified of the restrictions. R16 On January 9, 2025, at 12:46 p.m., R16 stated she had lived at the facility for seven years. R16	02130			

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02130	Continued From page 57 stated she was not able to come and go as she would like; she was only allowed to leave the facility for outings and the smoke breaks three times a day. R16 stated her guardian had asked for increased privileges in the past and the facility said no. R16 stated her guardian handles her finances, but she feels she is responsible enough to go outside when she wants to and feels as if they don't trust her. R16's unsigned, Service Plan Agreement printed January 9, 2025, indicated smoking escorts - get resident her cigarettes and supervise in smoking area for supervised breaks. Then return her cigarettes and lighter back to pantry. She is to be on supervised smoke breaks a 2:1 ratio. Retrieve tobacco product. Accompany resident to smoking area. Return tobacco products to storage. Provide escort to smoking area and storage of smoking items so items are not available in unit. Smoking: [R16's] well-being needs met with staff escort and storage of smoking supplies. [R16] is occasionally suspected to be found smoking in room. check pockets and drawers for cigarette butts after her scheduled smoke break. R16's IAPP included the following: - "Resident is a smoker. Resident has history of smoking in room. Resident is allowed to leave MC unit to go down to smoke during supervised smoke breaks - also has additional smoke breaks on her own." However, R16's interview indicated she was only allowed the three smoke breaks per day. - Although R16's smoking assessment indicated R16 was able to get to the smoking area independently, could light cigarette safely, disposed of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials; R16 required	02130			

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02130	Continued From page 58 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R17 On January 9, 2025, at 1:31 p.m., R17 was again observed sitting with his winter jacket and stocking cap on waiting by the entrance to the unit. R17 stated he was waiting for 2:00 p.m. so he could go out and smoke. R17 stated he had lived at the facility for two years. R17 verbalized his frustration with not being able to go outside to smoke because it makes him feel bad and anxious. R17 would like to go out to smoke more often. R17's unsigned, Service Plan Agreement printed on January 8, 2025, indicated R17 received smoking escorts- Resident is a 1:1 while smoking at all times. Will be taken out together or separately than other residents. Accompany resident to smoking area. Report to nurse if unsafe to smoke. Provide escort to smoking area - resident stores smoking items with community. R17's IAPP dated April 4, 2024, indicated R17 was unsafe to smoke unsupervised and included the following: 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R18 On January 9, 2025, at 1:40 p.m., the surveyor observed R18 sitting by the unit entrance wearing his winter jacket and stocking cap. R18 stated he had lived at the facility eight years. R18 verbalized his frustration with not being able to go outside to smoke because it makes him feel	02130			

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02130	Continued From page 59 bad. R18 had been sitting at the door waiting for 2:00 p.m. to go out to smoke, further stating if he missed a cigarette break, he wouldn't get one. R18's Service Plan Agreement signed July 16, 2024, did not include smoking escorts. R18's IAPP dated July 15, 2024, indicated R18 was able to get to the smoking area independently, could light cigarette safely, disposed of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials, R18 did have a tremor while smoking; R18 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R15 On January 9, 2025, at 1:45 p.m. R15 stated he was only allowed to smoke at 10 a.m., 2:00 p.m., and 6:00 p.m. R15 used expletive language expressing frustration with being unable to come and go freely or have alcohol. At 2:10 p.m., the surveyor asked R15 if he was going out to smoke and R15 stated, "it depends if anyone shows up to take us out. It depends how busy they are and what they are doing." R15's unsigned, Service Plan Agreement printed January 8, 2025, included smoking escorts - Resident has Hx of tobacco use and may wish to smoke, staff escort MC four times/day for 15 minutes, staff store tobacco and lighters. Retrieve tobacco product. Accompany resident to smoking area. Return tobacco products to storage. Provide escort to smoking area and storage of smoking items so items are not available in unit."	02130			

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02130	Continued From page 60 R15's IAPP dated July 15, 2024, indicated R15 was able to get to the smoking area independently, could light cigarette safely, dispose of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials, R15 had a tremor while smoking; R15 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. R15 and responsible party had been notified of the restrictions. On January 9, 2024, at 2:18 p.m., the surveyor observed an unidentified staff arrive to bring staff to smoke. The staff member talked with another ULP while the residents stood at the elevator waiting for her. At 2:21 p.m., the three residents and the staff went on the elevator. At the first floor, the residents went to a nursing office. A staff member handed each resident a cigarette, and the unidentified staff went out with them and assisted with lighting their cigarettes. All of the residents were dressed appropriately for the weather conditions. On January 8, 2025, at 1:20 p.m., CNS-B stated the smoking rules started during the COVID-19 pandemic when they separated each pod and allowed them to go out to smoke at certain times to segregate them. Prior to the pandemic, the non-memory care residents would share cigarettes or lighters with the memory care residents, who would then smoke in their rooms. The continued segregation during smoking times allows for less issues with sharing cigarettes. CNS-B further stated staff were at a ratio of one staff to four residents when they are off the memory care unit; therefore, the facility would not have enough staff to allow for the memory care residents to smoke whenever they want, but had	02130			

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02130	Continued From page 61 enough staff to accommodate it three times per day. The smoke breaks are in the residents' service plans and the case managers have all agreed to the frequency. The facility had tried to increase the smoke breaks, but the residents have "failed" and lost those "privileges." Memory care residents are not allowed to go out if the temperature is below 0 degrees or a wind chill of -15 degrees because they "do not dress appropriately for the weather. We have to treat all memory care residents the same." On January 9, 2024, at 3:11 p.m. CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A stated R18 had additional smoke breaks, but he failed, and it was taken away again. R16 had been allowed extra smoke breaks in the past but failed, and those privileges were taken away again. The licensee was considering increasing R17's "privileges" of smoke breaks; however, R17 has to put in a little work to get those privileges. "Care is individualized but currently the residents have failed with additional privileges, and that is why all of them are three times a day. If the facility [licensee] does for one resident, they have to do for all the residents." The residents have individualized service plans and IAPP's; however, the rules and policies apply to all the residents. The facility was currently staffed to safely accommodate three smoke breaks a day. Disallowed items R8 On January 8, 2025, at 9:15 a.m. ULP-K entered R8's room with the surveyor to assist with a transfer. R8 stated she was very upset because staff were taking stuff from her room and locking it up. R8 expressed frustration with the rules, further indicating it should be individualized. At	02130			

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02130	Continued From page 62 9:58 a.m., CNS-B assisted R8 into the wheelchair and CNS-B and ULP-K left the room. R8 stated she was upset that the staff take come into the room at night and take things to lock up. R8 further stated staff will not allow her to have her wheelchair in her room or her commode next to the bed. On January 8, 2025, at 10:00 a.m. CNS-B stated all of R8's stuff (crayons and markers) is locked up because she was in memory care. CNS-B further stated R8 has colored pencils she can use. The facility has a disallowed items list, and anything on that list is locked up. The resident can ask for their items and staff will get it for them, but they will lock it back up when they are done. R8's Service Plan Agreement signed on July 17, 2024, did not include any indication there were disallowed items in the memory care unit. R16 On January 9, 2025, at 12:46 p.m. R16 stated she was not allowed to have her personal items (laundry soap, shampoo, and other personal items) in her room, and they have to be locked up because "that's the rule." R16 further stated she doesn't understand why her stuff has to be locked up since she has never misused it. R16's unsigned, Service Plan Agreement printed January 9, 2025, included bathing assist "she may shower independently but personal care items must be locked between each use. Supervision to ensure safety. Nail care "assist the resident in trimming and filing her nails after each shower, items must be locked up after each use." Oral care-"resident is independent with her oral cares but will need to have items locked after	02130			

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02130	Continued From page 63 each use." Grooming - "set up resident to groom, 2 times daily, including oral care, products to be locked up after each use. Unlicensed assistive personnel to provide set up for grooming by laying out hairbrush, wash cloth and toothbrush, but the resident can complete the task independently. Facility staff to remind/provide assistance to return personal grooming/bathroom items back to the resident's room for storage and infection control as [facility] has Dorm style bathrooms." "MC - has locked cupboards for personal care Items to be kept and locked in, as they are not allowed in the residents' rooms due to safety concerns. Community to provide supportive assistance to assure resident is groomed." Hygiene: R16 "will be clean and well-groomed at all times Grooming: Personal care items such as shampoo, body wash, toothpaste is to be locked up after each use. Staff to lock back in designated cupboard." Personal laundry - R16 can do her own laundry but needs to lock up supplies after use. Safety check - "Check resident's room for shampoo, conditioner and other toiletries or inappropriate items that resident may have in her room that she should not have being on a locked memory care unit." "Remove items." An untitled and undated, document provided by the licensee identified the following: Items Residents cannot have on memory care-this is not all inclusive please ask the nurses if you have a question about something that may be dangerous to the MC residents or a non-food item they may eat. Rooms should be cleaned each shift and checked for contraband Medications including OTC Scissors Mini Fridge	02130			

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02130	Continued From page 64 markers/paint/craft supplies hand sanitizer (locked in cart) shampoo, conditioner, body wash, soap laundry soap, dryer sheets, oxy clean, downy etc makeup lotion Hairspray or styling products deodorant nail polish/remover razors anything with a cord rope/twine extension cords push pins, curling irons, hair dryer floss toothpaste nail clippers phone chargers-can be charged in pantry-no long cords computers will be charged in the pantry -no long cords. cleaning supplies including air freshener (needs to be in the bathroom closets) On January 8, 2025, at 1:09 p.m., CNS-B stated the disallowed items list was posted in both memory care areas. The disallowed items were a "long-term thing" because of safety problems in the past with those items listed. In addition, one resident has pica (an eating disorder in which a person eats things not usually considered food) and in order to keep her safe, they lock up any of those items for everybody on the unit because they "cannot watch her constantly." The residents can access their items anytime with supervision if they ask for them, use how they want, and then locked back up. No further information was provided.	02130			

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02130	Continued From page 65	02130			
02180 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide memory care residents with regular access to outdoor space. This had the potential to affect all memory care residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02180			

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02180	Continued From page 66 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, during a facility tour with housing manager (HM)-E at approximately 11:30 a.m., the surveyor observed a memory care unit on the third floor with secured entrances, and a memory care on the second floor with secured entrances. There was an entrance from the first floor to a secured outside area. On January 9, 2025, at 12:46 p.m., R16 stated she was not able to come and go as she would like, she was only allowed to leave the facility for scheduled outings and the smoke breaks three times a day. R16 complained she could not even go outside for fresh air if she wanted to. R16 stated her guardian had asked for increased privileges in the past and the facility said no. R16 stated living at the facility for seven years, and verbalized frustration with not being able to go outside more often. On January 9, 2024, at 1:31 p.m., the surveyor observed R17 waiting by the entrance to the secured unit wearing a winter jacket and stocking cap. R17 stated he was waiting for 2:00 p.m. so he could go outside and smoke. R17 would like to go outside more often, further explaining the past two days they hadn't been allowed to go outside to smoke because it was too cold. On January 9, 2025, at 1:40 p.m., the surveyor	02180			

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02180	Continued From page 67 observed R18 waiting by the entrance to the unit wearing a winter jacket and stocking cap. R18 stated he was waiting for the 2:00 p.m. smoke break and if he missed it, he would not be able to go out. R18 stated he had lived at the facility eight years. R18 would like to go out to smoke more often, but it was not allowed. On January 9, 2025, at 1:45 p.m., R15 used expletive language expressing frustration that they were only allowed to go outside to smoke three times a day, and that depends if anyone shows up to take them out and how busy the staff is and what they are doing. On January 9, 2024, at 2:18 p.m., an unidentified staff arrived on the floor to bring residents outside to smoke. The staff member talked with an unlicensed personnel (ULP) while all the residents stood at the elevator waiting for her. At 2:21 p.m., the three residents and the staff went on the elevator. At the first floor, the residents went to a nursing office. A staff member handed each resident a cigarette, and the unidentified staff went out with them and assisted with lighting their cigarettes. On January 8, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated the smoking rules started during the COVID-19 pandemic when they separated each pod and allowed them to go out to smoke at certain times to segregate them. Prior to the pandemic, the non-memory care residents would share cigarettes or lighters with the memory care residents, who would then smoke in their rooms. The continued segregation during smoking times allows for less issues with sharing cigarettes. CNS-B further stated staff were at a ratio of one staff to four residents when they are off the memory care unit; therefore, the	02180			

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02180	Continued From page 68 facility would not have enough staff to allow for the memory care residents to smoke whenever they want, but had enough staff to accommodate it three times per day. The smoke breaks are in the residents' service plans and the case managers have all agreed to the frequency. The facility had tried to increase the smoke breaks, but the residents have "failed" and lost those "privileges." Memory care residents are not allowed to go out if the temperature is below 0 degrees or a wind chill of -15 degrees because they "do not dress appropriately for the weather. We have to treat all memory care residents the same." On January 9, 2024, at 3:11 p.m., CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A stated R18 had additional smoke breaks, he "failed", and it was taken away again. R16 had been allowed extra smoke breaks in the past but "failed," and those "privileges" were taken away again. The facility was considering increasing R17's "privileges" of smoke breaks; however, the resident has to put in a little work too get those privileges. Care was individualized but the residents have failed with additional privileges, and that was why all of them are three times a day. The residents have individualized service plans and IAPP's; however, the rules and policies apply to all the residents. The surveyor observed a sign on the memory care door that read, "Memory Care Smoke Breaks are from: 10-11 AM, 2-3 PM, 6-7 PM Assisted Living Residents are NOT allowed in the courtyard for these 3 hours a day. Please plan your day as you will not be allowed to "sneak through" when they are outside. Thanks." No further information was provided.	02180			

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02180	Continued From page 69	02180			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of six of six residents (R16, R15, R11, R18, R12, R20) when the licensee required residents to follow house rules. This had the potential to affect all residents and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 6, 2025, at 11:24 a.m., the surveyor noted a sign posted on the main floor bulletin board dated February 17, 2023, that drugs and alcohol were strictly prohibited in the building. The licensee's Master Assisted Living Resident	02290			

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02290	Continued From page 70 Agreement included language on pages 13-14 titled Section 18.0 - Additional Resident Responsibilities. The Additional Resident Responsibilities section indicated 17 items that residents were required to follow and included: m. Not to consume alcohol or have open containers of alcohol in resident's Living Space, common areas or elsewhere on the premises, or to all Resident's guest(s) to do so, unless approved by the Facility An untitled and undated, document provided by the licensee identified the following: Items residents cannot have on memory care-this is not all inclusive -please ask the nurses if you have a question about something that may be dangerous to the MC (memory care) residents or a nonfood item they may eat. Rooms should be cleaned each shift and checked for contraband Medications including OTC Scissors Mini Fridge markers/paint/craft supplies hand sanitizer (locked in cart) shampoo, conditioner, body wash, soap laundry soap, dryer sheets, oxy clean, downy etc. makeup lotion Hairspray or styling products deodorant nail polish/remover razors anything with a cord rope/twine extension cords push pins, curling irons, hair dryer floss toothpaste	02290			

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02290	Continued From page 71 nail clippers phone chargers-can be charged in pantry-no long cords computers will be charged in the pantry -no long cords. cleaning supplies including air freshener (needs to be in the bathroom closets)" R16 R16 was admitted on August 15, 2018, and resided in one of the memory care units. On January 9, 2024, at 12:46 p.m., R16 stated the licensee did not allow drinking; it was "against the law" at the facility. R16 further stated she was not able to come and go as she would like; she was only allowed to leave the facility for outings and the smoke breaks three times a day. In addition, R16 may shower/groom independently, but R16's personal care items must be locked up between each use because of residing in a memory care unit. R16 stated her guardian had asked for increased privileges in the past and the facility said no. R16 stated her guardian handles her finances, but she was frustrated she was not able to go outside when she wanted. R16's unsigned, Service Plan Agreement printed January 9, 2025, read "Provide behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff." Staff	02290			

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02290	Continued From page 72 are to "remove all alcohol and substances from the facility and dispose of properly" and notify the registered nurse. Activities - "Facility will address the needs of each resident that will be person centered that promotes resident choice dignity and sustains the resident's abilities, Staff will promote interest from past and current interest, will include the current abilities and skills, enhance emotional and social needs. Staff will consider physical ability and limitations, facility will make reasonable adaptation necessary for the residents to participate, facility will consider and identify activities for behavior intervention." R15 R15 was admitted on March 24, 2022, and resided in one of the memory care units. On January 9, 2025, at 1:45 p.m., R15 used expletive language expressing frustration they could not come and go freely and could not have any alcohol. R15's unsigned, Service Plan Agreement printed on January 9, 2024, indicated Resident has history (Hx) of alcohol abuse, staff to monitor and notify nurse of any changes. Provide behavioral monitoring assure the resident is safe if choosing to drink alcohol. Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The community to provide a safe environment if the Resident chooses to consume alcohol. The community cannot take responsibility if the resident chooses to consume alcoholic substances. Activities - "facility will address the needs of each resident that will be person centered that promotes resident choice dignity and sustains the resident's abilities, Staff will promote interest from past and current interest, will include the current abilities and skills,	02290			

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02290	Continued From page 73 enhance emotional and social needs. Staff will consider physical ability and limitations, facility will make reasonable adaptation necessary for the residents to participate, facility will consider and identify activities for behavior intervention." R15's IAPP dated July 15, 2024, read "Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility and dispose of properly" and notify the nurse. R11 R11 was admitted on April 10, 2023, and resided in one of the memory care units. On January 9, 2025, at 12:30 p.m., R11 stated she was only allowed to go out to smoke three times per day. R11's unsigned, Service Plan Agreement printed January 8, 2025, indicated alcohol use - "Resident has a history of alcohol/substance use and abuse, and relapsing. Resident eloped from previous facility to obtain substances and alcohol." "If resident is exhibiting signs of impairment, staff are to notify nurse/hold meds/update medical provider." "When resident is exhibiting signs of impairment: provide simple verbal prompts and make sure resident is as safe as possible." "Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol." "Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The community to provide a safe environment if the Resident chooses to consume	02290			

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02290	Continued From page 74 alcohol. The community cannot take responsibility if the resident chooses to consume alcoholic substances." Activities - "Facility will address the needs of each resident that will be person centered that promotes resident choice dignity and sustains the resident's abilities, Staff will promote interest from past and current interest, will include the current abilities and skills, enhance emotional and social needs. Staff will consider physical ability and limitations, facility will make reasonable adaptation necessary for the residents to participate, facility will consider and identify activities for behavior intervention." R11's IAPP dated April 5, 2024, read "Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff. Staff to follow MAR if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility and dispose of properly" and notify the nurse. R18 On January 9, 2025, at 1:40 p.m., the surveyor observed R18 waiting by the unit entrance wearing a winter jacket and stocking cap. R18 stated he had lived at the facility eight years. R18 verbalized frustration with not being allowed to smoke more often, and if he missed a cigarette break, he wouldn't get one. R18's Service Plan Agreement signed by R18's guardian July 16, 2024, included substance use - monitor resident for substance use, report any unusual behaviors to the facially nurse, history of alcohol and OTC medications. Provide behavioral monitoring to assure the resident is safe If choosing to use recreational/controlled	02290			

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02290	Continued From page 75 substances. Team member to report to nurse or supervisor If the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded property by staff." "Staff to remove all alcohol and substances from the facility and dispose of properly. Staff to notify the nurse If this occurred. The community to provide a safe environment ff the resident chooses to use a recreational substance. The community cannot take responsibility if the resident chooses to use recreational/controlled substances." R12 R12 was admitted August 11, 2020, and resided in the non-secured area of the assisted living facility. R12 service plan agreement/care plan dated November 4, 2024, included "alcohol use: monitor if resident is drinking, how much, where at, is he making safe choices, did you report to nurse, did you document in his chart." The service plan agreement/care plan further noted staff would provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol, would report to nurse or supervisor if the resident appeared unsteady or intoxicated, and the community would provide a safe environment if the resident chose to consume alcohol. The service plan did not include any restriction related to drinking alcohol. On January 9, 2025, at 9:54 a.m. R12 stated he was not allowed to drink or have alcohol in his room. R12 stated he would like to have a beer every once in a while, but couldn't because the facility was "against" it.	02290			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER ELMORE ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST NORTH STREET ELMORE, MN 56027		
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02290	Continued From page 76 R20 On January 9, 2025, at 10:04 a.m. R20 (who resided in the non-secured area of the assisted living facility) stated the licensee had poured out his liquor in the past. R20 further expressed frustration that he could not have alcohol in his room. On January 8, 2025, at 1:09 p.m., clinical nurse supervisor (CNS)-B stated the disallowed items list was posted in both memory care areas. The disallowed items was a "long-term thing" because of safety problems with those items listed in the past. The residents have access to their items anytime if they ask for it. Bathing and grooming supplies are locked up and each resident has a spot. The resident can get their items with staff supervision, use it how they want, and then it is locked back up. On January 8, 2025, at 1:33 p.m., CNS-B stated the facility was drug and alcohol free so if they have alcohol in a public area, it is taken away and disposed of. Some of the residents have had drug and alcohol problems in the past and should not have it around them; therefore, none of the residents can have it at the facility. If they were to drink at the facility and be drunk and unmanageable they would have to call the police which would put a strain on emergency services. Therefore, the facility was a drug and alcohol-free facility, and all residents were to adhere to that. On January 9, 2025, at 3:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B stated the licensee was a drug and alcohol-free facility and the same resident agreement was utilized for all residents. CNS-B further stated the rule applied to all	02290			

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02290	Continued From page 77 residents and if alcohol was in plain sight, it would be removed and disposed of. The residents signed and agreed to this in their service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290			
02460 SS=C	144G.91 Subd. 18 Right to access food Residents have the right to access food at any time. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure snacks were available seven days per week when the facility restricted milk and juice at snack times. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 7, 2025, at 12:23 p.m., the surveyor	02460			

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02460	Continued From page 78 observed a sign on the locked kitchenette door that read "Residents are NOT to be given juice or milk outside of mealtimes unless a diabetic has a low blood sugar. Offer them water or they can go buy pop from the machine. They can also purchase things on the outings to drink." On January 7, 2025, at 1:16 p.m., clinical nurse supervisor (CNS)-B stated the kitchen tried to cut their budget by trying to not give the residents milk or juice at snack times. Although the sign instructed not to give residents milk or juice during snack time, the staff would still give it to the residents if they asked for it. On January 9, 2025, at 12:46 a.m., R16 stated they were not allowed to have juice or milk during snack times, and it would not be given to them if they asked for it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02460			
02550 SS=F	144G.911 RESTRICTIONS UNDER HOME AND COMMUNITY-BASED W The resident's rights in section 144G.91, subdivisions 12, 13, and 18, may be restricted for an individual resident only if determined necessary for health and safety reasons identified by the facility through an initial assessment or reassessment under section 144G.70, subdivision 2, and documented in the written service plan under section 144G.70, subdivision 4. Any restrictions of those rights for people served under chapter 256S and section 256B.49 must be documented by the case manager in the	02550			

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02550	Continued From page 79 resident's support plan, as defined in sections 256B.49, subdivision 15, and 256S.10. Nothing in this section affects other laws applicable to or prohibiting restrictions on the resident's rights in section 144G.91, subdivisions 12, 13, and 18. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have documented evidence for restricting rights as necessary for health and safety reasons by a case manager for five of five residents (R16, R11, R18, R17, R8) receiving assistance under community based waivers. 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 January 6, 2025, at 11:24 a.m., the surveyor noted a sign posted on the main floor bulletin board dated February 17, 2023, that drugs and alcohol were strictly prohibited in the building and disallowed items would be removed. The licensee's Master Assisted Living Resident Agreement included language on pages 13-14 titled Section 18.0 - Additional Resident Responsibilities. The Additional Resident Responsibilities section indicated 17 items that residents were required to follow and included: m. Not to consume alcohol or have open	02550			

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02550	Continued From page 80 containers of alcohol in resident's Living Space, common areas or elsewhere on the premises, or to all Resident's guest(s) to do so, unless approved by the Facility. R16 On January 9, 2024, at 12:46 p.m., R16 stated they were not allowed to have alcohol at the facility. R16 further stated she was not able to come and go as she would like; she was only allowed to leave the facility for outings and the smoke breaks three times a day. In addition, R16 may shower/groom independently, but R16's personal care items must be locked up between each use because of residing in a memory care unit. R16 stated her guardian had asked for increased privileges in the past and the facility said no. R16 stated her guardian handles her finances, but she was frustrated she was not able to go outside when she wanted. R16's unsigned, Service Plan Agreement printed January 9, 2025, indicated "Provide behavioral monitoring to assure the resident is safe if choosing to use recreational/controlled substances. Team member to report to nurse or supervisor if the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff." Staff are to "remove all alcohol and substances from the facility and dispose of properly" and notify the registered nurse. Activities - "Facility will address the needs of each resident that will be person centered that promotes resident choice dignity and sustains the resident's abilities, Staff will promote interest from past and current interest,	02550			

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02550	Continued From page 81 will include the current abilities and skills, enhance emotional and social needs. Staff will consider physical ability and limitations, facility will make reasonable adaptation necessary for the residents to participate, facility will consider and identify activities for behavior intervention". R16's Coordinated Services and Support Plan (CSSP) from the Department of Human Services (DHS) dated February 1, 2024, indicated areas of need included communication support, meals, socialization, transportation, med management, and behavioral supports. The plan did not include any restrictions agreed upon with the resident's case manager. R11 On January 9, 2025, at 12:30 p.m., R11 stated she was only allowed to go out to smoke three times per day. R11's unsigned, Service Plan Agreement printed January 8, 2025, did not include smoking assistance. Alcohol use - "Resident has a history of alcohol/substance use and abuse, and relapsing. Resident eloped from previous facility to obtain substances and alcohol." "If resident is exhibiting signs of impairment, staff are to notify nurse/hold meds/update medical provider." "When resident is exhibiting signs of impairment: provide simple verbal prompts and make sure resident is as safe as possible." "Provide behavioral monitoring to assure the resident is safe if choosing to drink alcohol." "Team member to report to nurse or supervisor if the resident appears unsteady or intoxicated. The community to provide a safe environment if the Resident chooses to consume alcohol. The community cannot take responsibility if the resident chooses	02550			

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02550	Continued From page 82 to consume alcoholic substances." Activities - "Facility will address the needs of each resident that will be person centered that promotes resident choice dignity and sustains the resident's abilities, Staff will promote interest from past and current interest, will include the current abilities and skills, enhance emotional and social needs. Staff will consider physical ability and limitations, facility will make reasonable adaptation necessary for the residents to participate, facility will consider and identify activities for behavior intervention." R11's IAPP dated April 5, 2024, included R11's smoking assessment. Although, the smoking assessment indicates R11 was able to get to the smoking area independently, could light cigarette safely, disposed of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials; R11 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. In addition, the facility was free of drugs and alcohol and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded properly by staff. Staff to follow MAR (medication administration record) if resident is on medication that can be affected by alcohol and substances. Staff to remove all alcohol and substances from the facility and dispose of properly, and notify the nurse. R11's CSSP dated March 1, 2024, indicated R11 lived in the memory care unit of the facility and received services including assistance with activities of daily living, medication management, meals, and transportation. R11's CSSP did not include any restrictions agreed upon with her	02550			

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02550	Continued From page 83 case manager. R18 On January 9, 2025, at 1:40 p.m., the surveyor observed R18 waiting by the unit entrance wearing a winter jacket and stocking cap. R18 stated he had lived at the facility eight years. R18 verbalized frustration with not being allowed to smoke more often, and if he missed a cigarette break, he wouldn't get one. R18's IAPP dated July 15, 2024, indicated R18 was able to get to the smoking area independently, could light cigarette safely, disposed of the cigarette safely, had no burn marks on her clothing, and had no past accidents or incidents with smoking materials, R18 did have a tremor while smoking; R18 required 1:1 supervision while smoking and all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R18's Service Plan Agreement signed by R18's guardian July 16, 2024, did not include smoking escorts. Substance use - monitor resident for substance use, report any unusual behaviors to the facility nurse, history of alcohol and over the counter medications. Provide behavioral monitoring to assure the resident is safe If choosing to use recreational/controlled substances. Team member to report to nurse or supervisor If the resident appears unsteady, intoxicated, or under the influence of a controlled substance. Educated by staff we are drug and alcohol free in the facility and when an item of drug/alcohol/substance or paraphernalia will be removed and discarded property by staff." "Staff to remove all alcohol and substances from the	02550			

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02550	Continued From page 84 facility and dispose of properly. Staff to notify the nurse if this occurred. The community to provide a safe environment if the resident chooses to use a recreational substance. The community cannot take responsibility if the resident chooses to use recreational/controlled substances." R18's Support Plan from the Department of Human Services (DHS) dated August 1, 2024, indicated R18 received assistance from staff with ADLs (activities of daily living), medication management, transportation, meals, and behavior management. R18's plan indicated when bathing and grooming he was independent, but his belongings were locked back up after use. No other restrictions agreed upon with a case manager were noted in the plan. R17 On January 9, 2025, at 1:31 p.m., the surveyor observed R17 waiting by the unit entrance wearing a winter jacket and stocking cap. R17 stated he was waiting for 2:00 p.m. so he could go out and smoke. R17 stated he had lived at the facility for two years. R17 verbalized frustration with not being allowed to go outside to smoke more often. R17's unsigned, Service Plan Agreement printed on January 8, 2025, indicated he received smoking escorts- "Resident is a 1:1 while smoking at all times. Will be taken out together or separately than other residents. Accompany resident to smoking area. Report to nurse if unsafe to smoke. Provide escort to smoking area - resident stores smoking items with community." R17's IAPP dated April 4, 2024, indicated R17 was unsafe to smoke unsupervised and included the following: 1:1 supervision while smoking and	02550			

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02550	Continued From page 85 all smoking materials were to be kept locked in the nursing station. Resident and responsible party had been notified of the restrictions. R17's CSSP dated May 1, 2024, indicated the following: - Although R17 was only allowed three smoke breaks per day, his CSSP indicated "[R17] smokes quite often throughout the day (up to a pack a day)." - R17 was limited to 4 times a day phone usage; and - R17's services included bathing, dressing, grooming, managing behaviors, medication management, and meals. No further restrictions were in the CSSP, agreed upon with the case manager. On January 8, 2025, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated the facility was drug and alcohol free so if they have alcohol in a public area, it is taken away and disposed of. Some of the residents have had drug and alcohol problems in the past and should not have it around them; therefore, none of the residents can have it at the facility. If they were to drink at the facility and be drunk and unmanageable, they would have to call the police which would put a strain on emergency services. Therefore, the facility was a drug and alcohol free facility and all residents were to adhere to that. On January 9, 2025, at 3:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and CNS-B stated the licensee was a drug and alcohol-free facility and the same resident agreement was utilized for all residents. CNS-B further stated the rule applied to all residents and if alcohol was out in plain sight it would be removed and disposed of. The	02550			

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02550	Continued From page 86 residents signed and agreed to this in their service plans. R8 On January 8, 2025, at 9:15 a.m., R8 verbalized frustration with not being allowed to keep her personal items in her room, including her wheelchair and a commode next to her bed. On January 8, 2025, at 10:00 a.m., CNS-B stated all of R8's stuff (crayons and markers) is locked up because she was in memory care. CNS-B stated R8 does have colored pencils she can use. The facility has a disallowed items list and anything on that list is locked up. The resident can ask for their items and staff will get it for them but will lock it back up when they are done with it. R8's Service Plan Agreement signed on July 17, 2024, did not include any indication there were disallowed items on the memory care unit. R8's Customized Living plan dated April 24, 2024, indicated R8 received assistance with ADLs, medication management, meals, and behavior management. The plan did not include any restrictions agreed upon with the case manager. An untitled and undated, document provided by the licensee identified the following: Items Residents cannot have on memory care-this is not all inclusive -please ask the nurses if you have a question about something that may be dangerous to the MC residents or a nonfood item they may eat. Rooms should be cleaned each shift and checked for contraband Medications including OTC Scissors Mini Fridge	02550			

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02550	Continued From page 87 markers/paint/craft supplies hand sanitizer (locked in cart) shampoo, conditioner, body wash, soap laundry soap, dryer sheets, oxy clean, downy etc. makeup lotion Hairspray or styling products deodorant nail polish/remover razors anything with a cord rope/twine extension cords push pins, curling irons, hair dryer floss toothpaste nail clippers phone chargers-can be charged in pantry-no long cords computers will be charged in the pantry -no long cords. cleaning supplies including air freshener (needs to be in the bathroom closets)" On January 8, 2025, at 1:09 p.m., CNS-B stated the disallowed items list was posted in both memory care areas. The disallowed items was a "long-term thing" because of safety problems with those items listed in the past. The residents have access to their items anytime if they ask for it. Bathing and grooming supplies are locked up and each resident has a spot. The resident can get their items with staff supervision, use it how they want, and then it is locked back up. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02550			

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Type: Full
Date: 01/07/25
Time: 11:00:00
Report: 1034251005

Food and Beverage Establishment Inspection Report

Page 1

Location:

Elmore Assisted Living
202 East North Street
Elmore, MN56027
Faribault County, 22

Establishment Info:

ID #: 0038706
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079433333
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
NEED CHLORINE TEST STRIPS FOR DISHWASHER.

Comply By: 01/17/25

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE TOP OF ONE CHEST FREEZER IS SITTING SLANTED. REPAIR SO THAT THE FREEZER PROPERLY SEALS ACCORDING TO MANUFACTURER SPECS.

Comply By: 01/22/25

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

BOXES OF SINGLE-SERVICE ARTICLES INCLUDING CUPS AND NAPKINS FOUND ON THE FLOOR. ELEVATE.

Comply By: 01/22/25

Surface and Equipment Sanitizers

Type: Full
Date: 01/07/25
Time: 11:00:00
Report: 1034251005
Elmore Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

Chlorine: = 100 at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Small Cooler
Temperature: 34.3 Degrees Fahrenheit - Location: Lettuce
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38.4 Degrees Fahrenheit - Location: Turkey
Violation Issued: No

Process/Item: Hot Holding
Temperature: 182 Degrees Fahrenheit - Location: Corn
Violation Issued: No

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: Pork
Violation Issued: No

Process/Item: 2-Door Cooler
Temperature: 39.6 Degrees Fahrenheit - Location: Whipping Cream
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38.4 Degrees Fahrenheit - Location: Juice
Violation Issued: No

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

Inspection conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Department of Health inspection report
number 1034251005 of 01/07/25.

Certified Food Protection Manager: Troy E Thompson

Certification Number: FM73313 Expires: 10/05/26

Inspection report reviewed with person in charge and emailed.

Signed: emailed

Troy Thompson
Executive Chef

Signed: McKenna Mathews

McKenna Mathews, RS
Public Health Sanitarian 2
Mankato District Office
507-344-2729
mckenna.mathews@state.mn.us