



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

July 11, 2024

Licensee

The Waterview Shores Assisted
409 13th Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL30733015

Dear Licensee:

On June 6, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 4, 2024 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 4, 2024, found not corrected at the time of the June 6, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0340 - Correction Orders - 144g.30 Subd. 5

1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E)

1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on June 6, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES ASSISTED		STREET ADDRESS, CITY, STATE, ZIP CODE 409 13TH AVENUE TWO HARBORS, MN 55616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30733015-2 AMENDED On June 5, 2024, through June 6, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 4, 2024, and a follow up survey on March 19, 2024. At the time of the survey, there were 38 resident(s); 20 receiving services under the provider's Assisted Living license.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 340} SS=D	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the	{0 340}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 340}	Continued From page 1 commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on June 6, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	{0 340}			

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{0 340}	Continued From page 2 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the revisit survey on June 5, 2024, through June 6, 2024, the surveyor reviewed the licensee's policies and procedures, reviewed resident records, conducted observations and interviews with licensed clinical manager/ licensed practical nurse (CM/LPN)-S, and unlicensed personnel (ULP)-R. The licensee lacked evidence to indicate the orders issued on March 19, 2024, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 340}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{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	{0 810}			

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{0 810}	Continued From page 3 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}			

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{01640}	Continued From page 4 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two residents (R6) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	{01640}			

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{01640}	Continued From page 5 The findings include: R6's diagnoses included diabetes without complications. R6's Assisted Living Agreement Addendum (service plan) dated June 7, 2022, indicated R6 received assistance with applying and removing TED (compression) stocking and to notify the RN (registered nurse) with any skin integrity concerns, redness, rash, increased swelling, or complaints of pain or with any difficulty in application. R6's service plan respectfully, lacked the assistance with applying and removing R6's AFO (ankle-foot orthosis) brace. R6's physician orders dated April 23, 2024, included assistance with applying and removing R6's AFO brace and to notify the nurse of any redness, swelling, or skin breakdown. On June 5, 2024, at 3:20 p.m., clinical manager/licensed practical nurse (CM/LPN)-S stated R6's Assisted Living Agreement Addendum dated June 7, 2022, had not been revised to include AFO brace application. The licensee's Service Plan Modification policy dated November 2019, noted the Service Plan or agreement must be modified due to a change in a prescriber's order or a change in the tenant's needs, a new Service Plan would be completed and included: -description of changes in service -frequency of new service or of old service if terminated -who is to perform the service -frequency of supervision -charge for the service -date/signature of registered nurse making	{01640}			

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{01640}	Continued From page 6 changes -date/signature of tenant or the tenant's representative each times a modification was made. No further information was provided.	{01640}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued for one of one resident (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{01890}			

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{01890}	Continued From page 7 R10's diagnosis included type II diabetes. R10's Assisted Living Agreement Addendum dated April 2, 2024, indicated R10 received medication administration to include Lantus (long-acting) insulin administration daily. R10's prescriber orders dated May 13, 2024, included Lantus Solostar insulin 20 units in the morning and six units in the evening. On June 5, 2024, at 10:39 a.m., the surveyor observed the medication cart with clinical manager/licensed practical nurse (CM/LPN)-S. CM/LPN-S confirmed R10's opened Lantus Solostar pre-filled insulin pen lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. Immediately following the surveyor and CM/LPN-S observed the medication refrigerator. CM/LPN-S confirmed R10's opened box of R10's Lantus Solostar prefilled insulin pens lacked prescription labels on the individual insulin pens. CM/LPN-S stated she would call the pharmacy to obtain labels. CM/LPN-S stated R10's insulin pens should have prescription labels and if not, staff need to notify her. No further information was provided.	{01890}			



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July 3, 2024

Licensee

The Waterview Shores Assisted

409 13th Avenue

Two Harbors, MN 55616

RE: Project Number(s) SL30733015

Dear Licensee:

On June 6, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 4, 2024 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 4, 2024, found not corrected at the time of the June 6, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

0480 - Minimum Requirements - 144g.41 Subd 1 (13) (i) (b) - \$500.00

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - \$500.00

1640 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (a-E)

1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on June 6, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by 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 Jessie Chenze at jessie.chenze@state.mn.us.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessica Chenze". The ink is dark and the signature is fluid.

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

JMD

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{0 340}	Continued From page 1 commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on June 6, 2024. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	{0 340}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
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{0 340}	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the revisit survey on June 5, 2024, through June 6, 2024, the surveyor reviewed the licensee's policies and procedures, reviewed resident records, conducted observations and interviews with licensed clinical manager/ licensed practical nurse (CM/LPN)-S, and unlicensed personnel (ULP)-R. The licensee lacked evidence to indicate the orders issued on March 19, 2024, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 340}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{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	{0 810}			

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{0 810}	Continued From page 3 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}			

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{01640}	Continued From page 4 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two residents (R6) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	{01640}			

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{01640}	Continued From page 5 The findings include: R6's diagnoses included diabetes without complications. R6's Assisted Living Agreement Addendum (service plan) dated June 7, 2022, indicated R6 received assistance with applying and removing TED (compression) stocking and to notify the RN (registered nurse) with any skin integrity concerns, redness, rash, increased swelling, or complaints of pain or with any difficulty in application. R6's service plan respectfully, lacked the assistance with applying and removing R6's AFO (ankle-foot orthosis) brace. R6's physician orders dated April 23, 2024, included assistance with applying and removing R6's AFO brace and to notify the nurse of any redness, swelling, or skin breakdown. On June 5, 2024, at 3:20 p.m., clinical manager/licensed practical nurse (CM/LPN)-S stated R6's Assisted Living Agreement Addendum dated June 7, 2022, had not been revised to include AFO brace application. The licensee's Service Plan Modification policy dated November 2019, noted the Service Plan or agreement must be modified due to a change in a prescriber's order or a change in the tenant's needs, a new Service Plan would be completed and included: -description of changes in service -frequency of new service or of old service if terminated -who is to perform the service -frequency of supervision -charge for the service -date/signature of registered nurse making	{01640}			

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{01640}	Continued From page 6 changes -date/signature of tenant or the tenant's representative each times a modification was made. No further information was provided.	{01640}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued for one of one resident (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	{01890}			

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{01890}	Continued From page 7 R10's diagnosis included type II diabetes. R10's Assisted Living Agreement Addendum dated April 2, 2024, indicated R10 received medication administration to include Lantus (long-acting) insulin administration daily. R10's prescriber orders dated May 13, 2024, included Lantus Solostar insulin 20 units in the morning and six units in the evening. On June 5, 2024, at 10:39 a.m., the surveyor observed the medication cart with clinical manager/licensed practical nurse (CM/LPN)-S. CM/LPN-S confirmed R10's opened Lantus Solostar pre-filled insulin pen lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. Immediately following the surveyor and CM/LPN-S observed the medication refrigerator. CM/LPN-S confirmed R10's opened box of R10's Lantus Solostar prefilled insulin pens lacked prescription labels on the individual insulin pens. CM/LPN-S stated she would call the pharmacy to obtain labels. CM/LPN-S stated R10's insulin pens should have prescription labels and if not, staff need to notify her. No further information was provided.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 12, 2024

Licensee

The Waterview Shores Assisted

409 13th Avenue

Two Harbors, MN 55616

RE: Project Number(s) SL30733015

Dear Licensee:

On March 19, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 4, 2024 survey.

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

0510-Infection Control Program-144g.41 Subd. 3
1290-Background Studies Required-144g.60 Subdivision 1 -\$500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1880-Storage Of Medications-144g.71 Subd. 19 -\$500.00
1890-Prescription Drugs-144g.71 Subd. 20 -\$500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1970-Treatment And Therapy Orders-144g.72 Subd. 6 -\$500.00

The details of the violations noted at the time of this follow-up survey completed on March 19, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on March 19, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00
0450-Minimum Requirements-144g.41 Subdivision 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by 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 Jessica Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessica Chenze".

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

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Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30733015-1 On March 18, 2024, through March 19, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 4, 2024. At the time of the survey, there were 37 residents: 21 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a	0 340			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on March 19, 2024. 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	0 340			

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0 340	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the revisit survey on March 18, 2024, through March 19, 2024, the surveyor reviewed the licensee's policies and procedures, reviewed resident records, conducted observations and interviews with clinical nurse supervisor (CNS)-A, licensed practical nurse (LPN)-J, and unlicensed personnel (ULP)-G, ULP-I. The licensee lacked evidence to indicate the orders issued on January 4, 2024, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by:	0 450			

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0 450	Continued From page 3 Based on interview and record review, the licensee failed to provide services in compliance with the Nurse Practice Act when the licensee failed to ensure registered nurse (RN) provided education to unlicensed personnel (ULP) for one of three residents (R12). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R12's unsigned Assisted Living Agreement Addendum/service plan dated March 12, 2024, indicated R12 received the following services: dressing/grooming assist, toileting assist, medication administration, bathing, housekeeping, linen changes, and pendant battery check. R12's progress note dated March 18, 2024, written by licensed practical nurse (LPN)-M at 6:23 p.m., noted, "received a call from staff that resident was throwing up and was all worked up and wanted someone to stay with her. Educated staff to call son and even if he could not come to visit, that maybe he could calm her down over phone. Also educated staff to continue to try to keep pushing water and if resident were hungry to do a bland diet." On March 18, 2024, at approximately 2:00 p.m., the posted March 2024 on-call calendar was	0 450			

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0 450	Continued From page 4 reviewed with clinical nurse supervisor (CNS)-A. CNS-A stated three of the five on-call nurses for March 2024 were LPNs. CNS-A said, "everyone is part of the 10:00 a.m. email, all of the nurses send out an update." On March 18, 2024, at 4:05 p.m., CNS-A stated it was not "ok" for LPNs to educate staff to provide a bland diet. CNS-A added it was "ok" for LPNs to educate ULPs (unlicensed personnel) to push fluids. CNS-A said she would look further into "this" (LPNs educating staff.) On March 19, 2024, at 6:29 a.m., ULP-I and ULP-G stated they both have called the on-call nurse number and when they call the on-line nurse number the person answering the phone did not indicate if they were an LPN or a RN. In addition, ULP-I and ULP-G stated "never" does the person answering the on-line nurse phone say they need to check with anyone else and call back later with further instruction. ULP-I and ULP-G stated they follow the direction they receive from the on-call nurse. The licensee's undated Defining the Role of the LPN policy noted: -providing health education: LPNs can educate residents and their families about health conditions, medications, and self-care strategies -assistance with training and education: LPNs can assist in providing training to staff, ensuring compliance with approved training materials and the involvement of RNs in competency evaluation -health promotion initiatives: LPNs can assist in organizing and promoting wellness programs, screenings, and educational events for residents and staff. In addition, collaboration: -LPNs collaborate with RNs, physicians, and	0 450			

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0 450	Continued From page 5 other healthcare professionals to ensure comprehensive care for residents -LPNs can collaborate with dietitians and food services to ensure resident's nutritional needs are met, including monitoring dietary restrictions and preferences. Further, participating in call: LPNs are expected to contact the designated RN with items outside of their scope of practice/anything requiring delegation and/or indication of change of condition of resident. Anything requiring further investigation is reported to the RN in real time. The 2023 Minnesota Statute section 138.171, Subd. 14, noted the scope of the LPN included: (1) conducting a focused assessment of the health status of an individual patient through the collection and comparison of data to normal findings and the individual patient's current health status, and reporting changes and responses to interventions in an ongoing manner to a registered nurse or the appropriate licensed health care provider for delegated or assigned tasks or activities; (2) participating with other health care providers in the development and modification of a plan of care; (3) determining and implementing appropriate interventions within a nursing plan of care or when delegated or assigned by a registered nurse; (4) implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider; (5) assigning nursing activities or tasks to other licensed practical nurses (LPNs); (6) assigning and monitoring nursing tasks or activities to unlicensed assistive personnel; (7) providing safe and effective nursing care delivery;	0 450			

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0 450	Continued From page 6 (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) assisting in the evaluation of responses to interventions; (11) collaborating and communicating with other health care providers; (12) providing health care information to individual patients; (13) providing input into the development of policies and procedures; and (14) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved practical nursing education program described in section 148.211, subdivision 1. The 2023 Minnesota Statutes section 138.171, Subd. 15, noted the scope of the RN included: (1) providing a comprehensive assessment of the health status of a patient through the collection, analysis, and synthesis of data used to establish a health status baseline and plan of care, and address changes in a patient's condition; (2) collaborating with the health care team to develop and coordinate an integrated plan of care; (3) developing nursing interventions to be integrated with the plan of care; (4) implementing nursing care through the execution of independent nursing interventions; (5) implementing interventions that are delegated, ordered, or prescribed by a licensed health care provider; (6) delegating nursing tasks or assigning nursing activities to implement the plan of care;	0 450			

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0 450	Continued From page 7 (7) providing safe and effective nursing care; (8) promoting a safe and therapeutic environment; (9) advocating for the best interests of individual patients; (10) evaluating responses to interventions and the effectiveness of the plan of care; (11) collaborating and coordinating with other health care professionals in the management and implementation of care within and across care settings and communities; (12) providing health promotion, disease prevention, care coordination, and case finding; (13) designing and implementing teaching plans based on patient need, and evaluating their effectiveness; (14) participating in the development of health care policies, procedures, and systems; (15) managing, supervising, and evaluating the practice of nursing; (16) teaching the theory and practice of nursing; and (17) accountability for the quality of care delivered, recognizing the limits of knowledge and experience; addressing situations beyond the nurse's competency; and performing to the level of education, knowledge, and skill ordinarily expected of an individual who has completed an approved professional nursing education program as described in section 148.211, subdivision 1. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

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{0 480}	Continued From page 8 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP)-I while providing assistance to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	{0 510}			

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{0 510}	Continued From page 9 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: ULP-I was hired on October 29, 2020, to provide direct care services to the facility's residents. On March 19, 2024, at 7:27 a.m., the surveyor observed ULP-I approach the locked medication cart. The surveyor did not observe ULP-I perform hand hygiene. ULP-I logged onto the computer system used, via an ipad positioned on top of the medication cart, and prepared R11's morning medication which included: -lactose liquid (liver disease) ULP-I poured the lactose into two plastic medication cups -several medications from 30-day preset up medication cards ULP-I punched the medication out of the cards and placed the medications into a medication cup -an orange fiber medication (bowel health) ULP-I took the bowel medication to the water dispenser and added water to it and stirred it up. ULP-I took the medication to R11's room. ULP-I left R11's medication on the kitchen counter in R11's room. ULP-I returned to the medication cart and documented R11's morning medications as given. The surveyor did not observe ULP-I perform hand hygiene after returning to the medication cart. On March 19, 2024, at 7:31 a.m., the surveyor observed ULP-I standing at the medication cart after documenting R11's medication as given. ULP-I unlocked the medication cart. The surveyor did not observe ULP-I perform hand hygiene.	{0 510}			

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{0 510}	Continued From page 10 ULP-I reviewed R11's record on the computer screen and removed a bottle of Tylenol (mild pain) and several medication cards from the medication cart. ULP-I prepared R13's medications placing them into a medication cup. ULP-I took the medication cup to R13's room and placed the medication on R13's table. ULP-I returned to the medication cart and documented R13's medication as given. The surveyor did not observe ULP-I perform hand hygiene after returning to the medication cart. On March 19, 2024, at 7:39 a.m., ULP-I stated she forgot to perform hand hygiene between residents, adding she should have. ULP-I removed a bottle of hand sanitizer from her pocket and applied it to her hands. On March 19, 2024, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated hand washing policy should be followed, the procedure was, hands should be washed if soiled. CNS-A added hand sanitizer could be used between residents and medication passes. The licensee's Handwashing policy dated November 2019, noted proper hand washing techniques should be used to protect the spread of infection. When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning (applying) and after removing gloves. Alcohol-based hand sanitizers should not be used as a replacement for proper and washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-backed hand sanitizer that contained at least 60% alcohol may be used to quickly reduce the number of germs on hands.	{0 510}			

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{0 510}	Continued From page 11 The licensee's Standard Precautions policy dated August 1, 2021, noted hands should be washed after removing gloves and after any direct contact with body secretions. No further information provided.	{0 510}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	{0 810}			

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{0 810}	Continued From page 12 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for three of three on-call nurses requiring background studies, (licensed practical nurse (LPN)-K, LPN-L), registered nurse (RN)-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01290}			

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{01290}	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2024, at approximately 2:00 p.m., the surveyor observed a nurse's note written in R12's record by on-call LPN-M, dated February 29, 2024: -6:23 p.m.: "received a call from staff that resident was throwing up and was all worked up and wanted someone to stay with her. Educated staff to call son and even if he could not come to visit, that maybe he could calm her down over phone. Also educated staff to continue to try to keep pushing water and if resident were hungry to do a bland diet." -7:23 p.m.: Update from staff a short time later that son called the hospital and hospital requested that resident be brought into ER (emergency room). Son was going to transport resident to the hospital. LPN-K LPN-K received her LPN license on December 7, 1988. LPN-K was hired on February 23, 2022, to provide direct care services to the licensee's residents for an affiliated facility which is under the same ownership, and to take nurse calls for this licensee, HFID 30733. LPN-K's record lacked documentation of a background study affiliated with the facility's	{01290}			

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{01290}	Continued From page 14 license. LPN-K's record included a background study for another license, 30699, which is under the same ownership. LPN-L LPN-L's received her LPN license on April 25, 2016. LPN-L was hired on March 21, 2023, to provide direct care services to the licensee's residents for an affiliated facility which is under the same ownership, and to take nurse calls for this licensee, HFID 30733. LPN-L's record lacked documentation of a background study affiliated with the facility's license. LPN-L's record included a background study for another license, 31, which is under the same ownership. RN-N RN-N received her RN license on June 29, 2012. RN-N was hired on January 1, 2024, to provide direct care and services to the licensee's residents and supervise the licensee's employees under the assisted living license for an affiliated facility which is under the same ownership, and to take nurse calls for this licensee, HFID 30733. RN-N's record lacked documentation of a background study affiliated with the facility's license. RN-N's record included a background study for another license, 20712, which is under the same ownership. On March 18, 2024, at 2:38 p.m., clinical nurse supervisor (CNS)-A noted on-call nurses have background studies completed with HFID numbers completed at their "respected building".	{01290}			

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{01290}	Continued From page 15 On March 18, 2024, at 2:42 p.m., CNS-A sent the surveyor an email that noted, "in reference to 133G.60 in accordance with section 144.057 background studies were required, related to "direct" care and access," when CNS-A was asked if the on-call LPN's required background studies for HFID30733. On March 18, 2024, at 4:11 p.m., administrator (A)-H stated the licensee did not have background studies completed for this licensee's HFID number for any nurse on the on-call list, "as they don't step foot in the building." A-H did confirm all the on-call nurses have access to "our" (licensees) Eldermark system (on-line computer system.) On March 19, 2024, at 6:44 a.m., CNS-A noted the on-call nurses have "full access" to the on-line computer system used, adding "they" (on-call nurses) can see anything that the primary site nurse can see." CNS-A confirmed the on-call nurses could also write notes in resident's records. The licensee's Background Study policy dated December 2016, noted background studies would be conducted on individuals providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to residents receiving services. In addition, contractors, or contract services: any contractor or employee of a contractor providing "direct contact" services, and any of the following applies: -the facility determines the tasks to be completed by the individual -the service provided by the individual are part of the required services offered by the facility	{01290}			

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{01290}	Continued From page 16 -the facility supervises or observes the individuals' performance -the facility has selection authority for which individual would provide the service. Further, background studies would be completed upon hire or facility transfer, employee completes Facility Background Study Form. No further information was provided.	{01290}			
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01640}			

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{01640}	Continued From page 17 review, the licensee failed to ensure one of two residents (R6) service plans were revised to include provided services. 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: R6's diagnoses included diabetes without complications. R6's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident to put on her TED stockings (compression). Notify RN with any skin integrity concerns, redness, rash, increased swelling, or complaints of pain or with any difficulty in application. R6's record included directions for staff, dated March 19, 2024, "please assist resident to put on her leg/foot braces (AFO). Notify RN (registered nurse) with any skin integrity concerns: redness, rash, increased swelling or complaints of pain or with any difficulty in application." On March 19, 2024, at 9:10 a.m., the surveyor observed ULP-G apply TEDs and AFO's to R6's lower legs.	{01640}			

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{01640}	Continued From page 18 On March 19, 2024, at 9:31 a.m., licensed practical nurse (LPN)-J stated R6's service plan was not revised to include AFO application. On March 19, 2024, at 11:54 a.m., LPN-J and administrator (A)-H stated not all of the resident's service plans had been updated as required. A-H confirmed R2's service plan had not been updated as required. LPN-J said she was working on updating service plans. The licensee's Service Plan Modification policy dated November 2019, noted the Service Plan or agreement must be modified due to a change in a prescriber's order or a change in the tenant's needs, a new Service Plan would be completed and included: -description of changes in service -frequency of new service or of old service if terminated -who is to perform the service -frequency of supervision -charge for the service -date/signature of registered nurse making changes -date/signature of tenant or the tenant's representative each times a modification was made. No further information was provided.	{01640}			
{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	{01760}			

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{01760}	Continued From page 19 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance 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 as ordered for two of three residents (R11, R10) who received medication management services. 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: R11 R11's diagnoses included metabolic encephalopathy (chemical imbalance in the blood affecting the brain.) R11's Assisted Living Agreement Addendum/service plan dated February 20, 2024, indicated R11 received services which included medication administration daily:	{01760}			

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{01760}	Continued From page 20 -administer resident's medication per EMAR (electronic medication administration record) orders. Identify client (resident), introduce yourself, explain what you are going to do and provide privacy. Review the six rights of medication administration. 1) medication 2) route 3) time 4) client 5) dosage 6) documentation wash hands, explain what the medication is and what you are giving it for. Remove medication from packages and put into medication cup. Hand medication cup to client and offer water or another liquid/other food source per care plan to facilitate swallowing. Ensure client has swallowed medication, document. R11's MAR dated March 1, 2024, through March 18, 2024, included: -warfarin (blood thinner/heart) 2.5 milligrams (mg) three tablets once weekly on Friday -diltiazem (heart) 120 mg two capsules daily -Flintstone chewable vitamin (supplement) one daily -furosemide (heart/diuretic, remove fluid) 20 mg twice daily -lactulose solution (hepatic encephalopathy) 45 milliliters (ml) twice daily -levetiraceta (seizures) 500 mg twice daily -omeprazole (stomach acid) 20 mg daily -potassium chloride (supplement) 20 milliequivalents (meq) two tablets daily -sertraline (depression) 50 mg daily -vitamin B-12 (supplement) sublingually daily -vitamin D3 (supplement) 25 micrograms (mcg) daily	{01760}			

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{01760}	Continued From page 21 R11's RN (registered nurse) Assessment dated February 16, 2024, noted: Needs Assistance: dexterity (sp) and fine motor issues. Medication trained PCA (personal care attendant/ unlicensed personnel/ULP) to administer all medications Problem Areas/Limitation: loss of sensation-abilities to perform fine motor activities; dexterity and fine motor issues Service Needed Based on Assessment: medication trained PCA staff to administer all medications. Medication trained PCA staff document after medications administration in MAR. On March 19, 2024, at 7:27 a.m., the surveyor observed ULP-I prepared R11's morning medication. ULP-I took the medication to R11's room. ULP-I left R11's medication on the kitchen counter in R11's room. ULP-I returned to the medication cart and documented R11's morning medications as given. On March 19, 2024, at 12:22 p.m., the surveyor reviewed R11's medication assessment and MAR with licensed practical nurse (LPN)-J. LPN-J stated ULP-I should have observed R11 take the morning medication per assessment. In addition, R11's MAR did not contain any direction for ULPs to leave R11's medications unattended. R10 R10's diagnoses included diabetes. R10's signed Assisted Living Agreement Addendum/service plan dated March 18, 2024, indicated R10 received glucometer checks (blood sugar) four times daily. LPN-J stated she had a new service plan printed out awaiting a signature; insulin administration had been added.	{01760}			

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{01760}	Continued From page 22 On March 19, 2024, at approximately 6:55 a.m., ULP-I stated she gave R10 four units of insulin yesterday, but added she did not feel comfortable doing so. She stated she followed the instructions attached to the plastic bag R10's insulin pens were stored in. On March 19, 2024, at 7:20 a.m., ULP-I stated she told LPN-J yesterday R10's insulin was not on R10's EMAR. ULP-I said LPN-J fixed it. The surveyor reviewed R10's EMAR with ULP-I. The surveyor observed R10's EMAR screen which noted: -blood sugar checks: check before meals. Hold insulin if less than 100. On March 19, 2024, at 11:35 a.m., ULP-I stated she gave R10 four units of insulin. ULP-I said R10's insulin was not in R10's EMAR adding no documentation of insulin administration had been completed. R10's prescriber's order dated January 25, 2024, included: -Humalog Kwik Pen (fast acting insulin) 100 units/ml, four units prior to breakfast, lunch, and supper, hold if glucose less than 100 -Lantus (long-acting insulin) 100 units/ml, inject 24 units once daily. On March 19, 2024, at 9:28 a.m., LPN-J stated "we" (facility) started to administer R10's insulin on "Thursday or Friday." On March 19, 2024, at 10:24 a.m., R10's EMAR was reviewed with LPN-J. LPN-J said she reached out to clinical nurse supervisor (CNS)-A "last night" via email regarding R10's EMAR. LPN-J stated CNS-A said she would "look into it.	{01760}			

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{01760}	Continued From page 23 (EMAR issue.) LPN-J confirmed there was no direction for ULP of what insulin to give, how much to give, or when to give insulin on R10's EMAR. In addition, LPN-J confirmed there was no record of what insulin had been administered to R10. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted the register nurse (RN) developed individualized medication plans that included verification that all medication, treatments, and therapies were administered as prescribed and monitoring of medication use to prevent possible complications of adverse reactions. No further information was provided.	{01760}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01880}			

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{01880}	Continued From page 24 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: On March 18, 2024, at 10:14 a.m., the surveyor reviewed the contents of the locked medication refrigerator with licensed practical nurse (LPN)-J. LPN-J stated the current temperature of the medication refrigerator was 32 degrees Fahrenheit (F). LPN-J stated she could not remember what the temperature was supposed to be and was looking around the immediate area and commented at the nursing home "they" (facility) had the temperature range posted. The Temperature log dated March 1, 2024, through March 18, 2024, indicated the temperature was monitored 18 of 18 opportunities. Of the 18 opportunities: -13 of the 18 opportunities the temperature was documented under 36 degrees, ranging from 32-34 degrees -one time "yes" was documented. The medication refrigerator contained: -16 unopened Trulicity (once-weekly medication for diabetes) pens for R4 -one unopened Tresiba (manage blood sugar levels/diabetes) 200 units per pens for R4 -six unopened Lantus (long-acting insulin/diabetes) 100 units/milliliters (ml) pens for R10 -six unopened Humalog (fast acting insulin/diabetes) 100 units/ml pens for R10 -two unopened latanoprost (high eye pressure)	{01880}			

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{01880}	Continued From page 25 0.005% eye solution for R2. On March 18, 2024, at 11:47 a.m., the temperature log was reviewed with LPN-J and administrator (A)-H, and they confirmed the medication refrigerator temperature was not within correct limits. A-H said staff should be reaching out to himself, or the nurse, or supervisor, if/when the temperature was not within acceptable limits. The manufacturer's instructions for Trulicity dated November 2022, noted store pen in the refrigerator between 36 to 46 degrees F, you may store pen at room temperature below 86 degrees for up to a total of 14 days. The manufacturer's instructions for Tresiba insulin pens dated July 2022, noted store unopened Tresiba in the refrigerator at 36 degrees F to 46 degrees F in the original carton to protect from light. Do not freeze Tresiba. Do not use Tresiba if it had been frozen. The manufacturer's instructions for Lantus insulin pens dated August 2022, noted unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Humalog insulin pens dated December 5, 2022, noted unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Humalog to freeze. The manufacturer's instructions for latanoprost dated August 15, 2023, noted unopened bottles should be stored in the refrigerator (36 to 46 degrees F).	{01880}			

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{01880}	Continued From page 26	{01880}			
	The licensee's Storage of Medications policy dated December 2019, noted medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).				
	No further information was provided.				
{01890} SS=F	144G.71 Subd. 20 Prescription drugs	{01890}			
	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 with legible information including the expiration date for time sensitive medications for two of two residents (R2, R10).				
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).				
	The findings include:				

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{01890}	Continued From page 27 On March 18, 2024, at approximately 10:30 a.m., the surveyor reviewed the contents of the locked medication cart with licensed practical nurse (LPN)-J. LPN-J observed and confirmed the following: -one opened bottle of latanoprost 0.005% ophthalmic solution (glaucoma medication/high eye pressure) did not have a label which indicated the date the bottle of latanoprost had been opened and when the bottle of solution would expire for R2 -one opened Lantus 100 units/milliliters (ml) (long-acting) insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire for R10 -one opened Humalog 100 units/ml (short acting) insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire for R10. Directly after the above observation, LPN-J stated R2's latanoprost bottle noted it would expire September 2025. LPN-J said she was not aware some eye solutions needed to be dated. The surveyor reviewed the manufacturer's instructions with LPN-J for R2's latanoprost and LPN-J confirmed time sensitive medication should have been dated. In addition, R10's insulin pens had a sticker attached to each of them which included a place to write date open/ date expired, which were both blank. The manufacturer's instructions for latanoprost eye solution dated August 15, 2023, directed eye solution could be used for up to six weeks when stored at room temperature, under 77 degrees Fahrenheit (F). The manufacturer's instructions for Lantus insulin	{01890}			

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{01890}	Continued From page 28 pens dated August 2022, indicated after first use, after 28 days, throw your opened Lantus pen away, even if it still had insulin in it. The manufacturer's instructions for Humalog insulin dated December 5, 2022, indicated after first use, after 28 days, throw your opened Humalog pen away, even if it still had insulin in it. The licensee's Storage of Medications policy dated December 2019, noted medications shall be stored consistent with manufacturer's recommendations. No further information was provided.	{01890}			
{01940} SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	{01940}			

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{01940}	Continued From page 29 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R2) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the initial entrance conference on January 2, 2024, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C and administrator (A)-H confirmed the licensee provided treatment and therapy services to residents. R2's Assisted Living Agreement Addendum/service plan dated January 25, 2024,	{01940}			

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{01940}	Continued From page 30 indicated R2 received assist with toileting, incontinent care, dressing/grooming, escort assist, and medication administration. R2's prescriber's order dated March 15, 2024, noted: -replace Band-Aid on left big toe once daily for five days then can discontinue, watch for any signs of infection. R2's record dated March 18, 2024, included instructions for unlicensed personnel (ULP) to monitor R2's toe for warmth, redness, and drainage with Band-Aid changes. R2's record did not include what and when to report concerns to nursing. On March 18, 2024, at 12:28 p.m., R2's record was reviewed with licensed practical nurse (LPN)-J. LPN-J stated R2's record should have included when and what to report to nursing. LPN-J added, she had it (what to report to nursing) in R2's record but she removed the information "as it was a lot of words." The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted the RN would develop and would identify any specific client (resident) instructions regarding medication, treatments or therapy our agency staff would administer, to include, the procedure for staff to notify the RN when there is a problem. No further information was provided.	{01940}			
{01970} SS=F	144G.72 Subd. 6 Treatment and therapy orders	{01970}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01970}	Continued From page 31 There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R6, R8) who received the treatment of ankle-foot orthoses (AFO/BRACE) managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial entrance conference on January 2, 2024, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C and administrator (A)-H confirmed the licensee provided treatment and therapy services to residents. R6 R6's diagnoses included diabetes.	{01970}			

Minnesota Department of Health

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{01970}	Continued From page 32 R6's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident to put on her TED stockings (compression). Notify RN with any skin integrity concerns, redness, rash, increased swelling or complaints of pain or with any difficulty in application. R6's record included directions for staff, dated March 19, 2024, "please assist resident to put on her leg/foot braces (AFO). Notify RN with any skin integrity concerns: redness, rash, increased swelling or complaints of pain or with any difficulty in application." On March 19, 2024, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-G apply TEDs and AFO's to R6's lower legs. R8 R8's diagnoses included diabetes, cerebral infarction (disrupted blood supply and restricted oxygen supply/stroke,) hemiplegia hemiparesis affecting right domain (paralysis of one side of the body,) and osteoporosis (bones become brittle and fragile from loss of tissue.) R8's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident with lower extremity dressing. She wants help getting her pants, socks, brace, and shoes on daily. R6's record included directions for staff, dated March 19, 2024, "please assist resident to put on her leg/foot braces (AFO). Notify RN (registered nurse) with any skin integrity concerns: redness, rash, increased swelling or complaints of pain or	{01970}			

Minnesota Department of Health

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{01970}	Continued From page 33 with any difficulty in application." On March 19, 2024, at 9:02 a.m., the surveyor observed ULP-G apply socks and an AFO to R8's left foot. On March 19, 2024, at 11:59 a.m., licensed practical nurse (LPN)-J stated she was not able to find orders for AFO's in R6 and R8's records. On March 19, 2024, at 1:01 p.m., the surveyor received an email from CNS-A which noted, "we" (licensee), "do not have the proper documentation within the notes which is our policy or the order on site." CNS-A confirmed the order was not corrected as required. The licensee's Medication and Treatment Orders policy dated December 2019, noted the RN was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the client's (residents) records, communicated to the client or responsible party, educate client or responsible part on all medication and treatment orders, and that changes in orders are addressed in the resident's service plan are are communicated to the other staff. No further information was provided.	{01970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 29, 2024

Licensee

The Waterview Shores Assisted Living
409 13th Avenue
Two Harbors, MN 55616

RE: Project Number(s) SL30733015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17.

MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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>

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.

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 cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30733015 On January 2, 2024, through January 4, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 35 residents; 17 receiving services under the Assisted Living license. An immediate correction order was identified on January 3, 2024, issued for SL30733015, tag identification 2310. On January 3, 2024, the immediacy of correction order 2310 was removed, however noncompliance remained at a scope and level of G.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2024
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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510			

Minnesota Department of Health

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0 510	Continued From page 2 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed by one of one unlicensed personnel (ULP)-G while providing direct care to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-G was hired on September 27, 2022, to provide direct care services to the facility's residents. ULP-G's employee record indicated ULP-G had received competency training to include infection control on September 27, 2022. On January 3, 2024, at 6:49 a.m., the surveyor observed ULP-G enter R8's room and readied clothing for R8. ULP-G made R8's bed and then dressed R8 with pants, socks, right ankle-foot orthoses (AFO/brace) and dressed R8's upper body. ULP-G left R8's room and went to	0 510			

Minnesota Department of Health

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0 510	Continued From page 3 medication room and got a pair of gloves. ULP-G went to the kitchen to get R8 a yogurt. ULP-G returned to R8's room and put on gloves and prepared R8's breakfast (toast, yogurt with fruit, coffee.) ULP-G removed gloves. The surveyor did not observe ULP-G wash hands or use hand sanitizer. On January 3, 2024, at 7:13 a.m., the surveyor observed ULP-G enter R7's room. ULP-G put on gloves. The surveyor did not observe ULP-G wash hands prior to glove placement. ULP-G handed R7 a container of cranberry juice. ULP-G went to R7's bedroom and picked up a crock that contained a jug with hose attached. ULP-G took the crock to the bathroom and emptied the jug that contained urine into the toilet. ULP-G put water into the hose from the vanity sink and dumped it out into the toilet and repeated the process. ULP-G flushed R7's toilet and took the crock and jug with hose and placed it near R7's closet. ULP-G removed gloves and went up to R7 and gave her a hug. ULP-G picked up the iPad to document. Directly after the above observation at 7:20 a.m., ULP-G stated she forgot to use sanitizer, adding sanitizer was in her locker. On January 3, 2024, at 7:23 a.m., the surveyor observed ULP-G go to the medication room and retrieve a blood pressure cuff. ULP-G took a basket of clothing from the hallway into R2's room and continued to R6's room. The surveyor observed ULP-G apply gloves. The surveyor did not observe ULP-G wash hands prior. ULP-G applied compression stockings (TEDs) to R6's legs and AFO's to R6's feet and lower legs. On January 3, 2024, at 7:31 a.m., the surveyor	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 observed ULP-G remove a blood pressure cuff from a small, zippered bag and place the cuff on R6's left arm. A reading of 152/90 was obtained. ULP-G removed the blood pressure cuff and returned it to the small, zippered bag. ULP-G then unzipped the bag and looked at the screen and documented R6's blood pressure on the iPad. ULP-G then zipped the bag up and returned it to the medication room. On January 3, 2024, at 7:37 a.m., ULP-G stated she was not aware the blood pressure cuff needed to be cleaned/disinfected. On January 3, 2024, at 12:20 pm., clinical nurse supervisor (CNS)-C stated her expectation was hands were washed in between each resident and before and after medication, or any cares, and when gloves are put on or taken off. CNS-C said reusable equipment should be cleaned in between each resident use. The licensee's Handwashing policy dated November 2019, noted proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: before, during, and after preparing food. In addition, when conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning (applying) and after removing gloves. Alcohol-based hand sanitizers should not be used as a replacement for proper and washing when hands are visibly soiled. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-backed hand sanitizer that contained at least 60% alcohol may be used to quickly reduce the number of germs on hands. The licensee's Standard Precautions policy dated	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 August 1, 2021, noted hands should be washed after removing gloves and after any direct contact with body secretions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individual abuse prevention plans (IAPP) with the required content were developed for all individuals residing in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at widespread scope (when problems	0 630			

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0 630	Continued From page 6 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on January 2, 2024, at approximately 12:30 p.m., administrator (A)-H stated the facility employed one contracted staff, unlicensed personnel (ULP)-F. ULP-F was hired on November 28, 2022, to provide direct care to the licensee's residents. On January 3, 2023, at approximately 12:00 p.m., it was brought to the surveyor's attention that room number 118 was occupied by contracted personnel. On January 3, 2024, at 1:32 p.m., A-H stated rooms occupied by contracted personnel were: 118, 203, 204, 216, 220. On January 3, 2024, at 2:44 p.m., A-H stated IAPP's had not been developed for any of the contracted personnel residing at the facility. A-H added some of the contracted staff residing at the facility were employed to work at the adjacent long term care facility. A-H said he was unaware IAPPs were required. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to be free from physical, sexual, and emotional abuse: neglect; financial exploitation; and all form of maltreatment covered under the Vulnerable Adults Act. No further information was provided.	0 630			

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0 630	Continued From page 7	0 630			
	TIME PERIOD FOR CORRECTION: Two (2) days				
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of one employee (unlicensed personnel (ULP-G), and all other ULPs working at the facility for training and competency evaluations for ankle-foot orthoses (AFO/brace.)	0 650			

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0 650	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-G was hired on September 27, 2022, to provide direct care services to the facility's residents. On January 3, 2024, at 6:49 a.m., the surveyor observed ULP-G make R8's bed and then dress R8 with pants, socks, and right AFO. On January 3, 2024, at 7:23 a.m., the surveyor observed ULP-G apply TEDs to R6's legs and AFOs to R6's feet and lower legs. On January 3, 2024, at 2:50 pm., clinical nurse supervisor (CNS)-C stated ULPs were trained by physical therapy (PT) for AFOs. CNS-C confirmed there was no documentation of AFO training and competency evaluations in ULP's records. The licensee's Orientation of Assisted Living Staff policy dated August 1, 2021, noted evidence of the completion of required orientation topics must be kept in the employee record of each staff person having completed the orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 650			

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0 650	Continued From page 9 (21) days	0 650			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide required training documentation. 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 3, 2024, maintenance director (MD)-E provided documents on the fire safety and evacuation plan (FSEP) for the facility, fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On January 3, 2024, at 11:00 a.m., survey staff toured the facility with MD-E and regional maintenance (MR)-D. During the facility tour, survey staff observed the resident room numbers were very small and not legible on the emergency exit plans posted in the facility. The fire plan failed to clearly identify the location and number of resident rooms. The resident room numbers were very small and not legible on the floor plans included in the fire plan binder. During an interview with survey staff on January 3, 2024, at 1:30 p.m., MD-E verified the evacuation plans failed to clearly identify the location and number of all resident rooms. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon	0 810			

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0 810	Continued From page 11 hire and/or at least twice per year as evident by the lack of training documentation. Two training records were provided. One record, dated May 25, 2023, documented an employee training session on the facility FSEP. A second training record, dated November 10, 2023, documented the FSEP training completed with a newly hired employee. During an interview with survey staff on January 3, 2024, at 1:30 p.m., MD-E verified additional employee training records were not available. MD-E stated additional employee training on the facility FSEP had been completed in the last year but was not documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900			

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0 900	Continued From page 12 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract, with the required content for contracted unlicensed personnel (ULP)-F and for other contracted personnel working in the adjacent long term care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2024, at approximately 12:30 p.m., administrator (A)-H stated the facility employed one contracted staff, unlicensed personnel (ULP)-F. On January 3, 2023, at approximately 12:00 p.m., it was brought to the surveyor's attention that room number 118 was occupied by contracted	0 900			

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0 900	Continued From page 13 personnel. ULP-F had a start dated of November 29, 2022. On January 3, 2024, at 1:32 p.m., A-H stated rooms occupied by contracted personnel were: 118, 203, 204, 216, 220. On January 3, 2024, at 2:44 p.m., A-H stated there were no contracts for the personnel staying at the assisted living facility. A-H confirmed he was unaware of the regulation that an assisted living may not provide housing to any individual unless it had executed a contract. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 900			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290			

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01290	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of three employee (unlicensed personnel/ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G was hired on September 27, 2022, to provide direct care services to the licensee's residents. On January 3, 2023, at 7:23 a.m., the surveyor observed ULP-G take R6's blood pressure. ULP-G's record lacked documentation of a background study affiliated with the facility's license. ULP-G's record included a background study for another license, 21265, which is under the same ownership. On January 4, 2024, at 1:12 p.m., administrator (A)-H stated the provider had not completed a background study affiliated with license for ULP-G. The licensee's Background Study policy dated December 2016, noted background studies would	01290			

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01290	Continued From page 15 be completed on all employees. Human Resource Director would: -verify that the information on the form was correct. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	01440			

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01440	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-G was hired on September 27, 2022, to provide direct care to the licensee's residents. On January 2, 2023, at 7:23 a.m., the surveyor observed ULP-G take R6's blood pressure. ULP-G's employee record did not include documentation of a registered nurse (RN) supervising ULP-G performing a delegated task within 30 days of beginning work with the licensee. On January 4, 2024, at 11:31 a.m., clinical nurse supervisor (CNS)-C stated she was not aware of the requirement. CNS-C confirmed she had not completed supervision of ULPs performing a delegated task within 30 days for any of the licensee's ULPs. The licensee's Supervision of ULP policy dated	01440			

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01440	Continued From page 17 December 2019, noted ULP must be supervised by an RN within 30 days after the date on which the individual began working for the home care provider and first performed delegated tasks for the clients (residents) and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620			

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01620	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool which included all required assessment content, not to exceed 90 days from previous assessment for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 started receiving assisted living services by the licensee on September 14, 2021. R4's diagnoses included diabetes without complications, hypertension (HTN/high blood pressure), and illness, unspecified. R4's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R4 received assist with ambulation, mandatory assessments, home health aide services, laundry, housekeeping, and linen change. On January 3, 2024, at 11:37 a.m., the surveyor observed licensed practical nurse (LPN)-B check	01620			

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01620	Continued From page 19 R4's blood sugar. R4's most current assessment was dated September 4, 2023, (120 days from assessment to survey date). R4's record lacked further assessments were available for review. R4's record lacked documentation the facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident. On January 3, 2024, at 11:07 a.m., LPN-B stated R4's assessment was not completed within 90 days of the previous assessment. On January 4, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-C confirmed R4's 90-day assessment was not completed as required. The licensee's Assessments-Schedule policy dated December 2019, noted ongoing resident monitoring and reassessments would be completed at least every 90 days, face to face with resident by a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640			

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01640	Continued From page 20 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three residents (R4, R6) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4's diagnoses included diabetes without	01640			

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01640	Continued From page 21 complications, hypertension (HTN/high blood pressure), and illness, unspecified. R4's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R4 received assist with ambulation, mandatory assessments, home health aide services, laundry, housekeeping, and linen change. R4's December 1, 2023, through December 31, 2023, medication administration record (MAR) included: -blood glucose check, check resident's blood glucose with reader. On January 3, 2024, at 11:37 a.m., the surveyor observed licensed practical nurse (LPN)-B check R4's blood glucose. On January 4, 2024, at 9:28 a.m., LPN-B stated R4's service plan was not revised to include blood glucose monitoring. R6 R6's diagnoses included diabetes, cerebral infarction (disrupted blood supply and restricted oxygen supply/stroke,) hemiplegia hemiparesis affecting right domain (paralysis of one side of the body,) and osteoporosis (bones become brittle and fragile from loss of tissue.) R6's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R6 received assist with dressing/grooming, bathing, home health aide services, mandatory assessments, escorts, toileting, nail care by a nurse, laundry, housekeeping, and linen change.	01640			

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01640	Continued From page 22 R6's Service Received record dated December 1, 2023, through December 31, 2023, noted check vital signs were documented as completed daily. On January 3, 2024, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-G place an ankle-foot orthoses (AFO/brace) on R6's left foot. On January 3, 2024, at 7:31 a.m., the surveyor observed ULP-G place a blood pressure cuff on R6's left arm and received a reading of 152/69. On January 4, 2024, at 9:31 a.m., LPN-B stated R6's service plan was not revised to include blood pressure monitoring. LPN-B added R6 wanted her blood pressure checked. In addition, LPN-B stated R6 could apply the AFO herself. On January 4, 2024, at approximately 1:15 p.m., clinical nurse supervisor (CNS)-C confirmed R4 and R6's service plans were not revised as required. The licensee's Service Plan Modification policy dated November 2019, noted the Service Plan or agreement must be modified due to a change in a prescriber's order or a change in the tenant's needs, a new Service Plan would be completed and included: -description of changes in service -frequency of new service or of old service if terminated -who is to perform the service -frequency of supervision -charge for the service -date/signature of registered nurse making changes -date/signature of tenant or the tenant's representative each time a modification was made.	01640			

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01640	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance 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 as ordered for one of three resident (R9) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01760			

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01760	Continued From page 24 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R9's diagnoses included multiple myeloma not having achieved remission (cancer), major depressive disorder, and hypertension (HTN/high blood pressure.) R9's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R9 received services which included medication administration daily: -administer resident's medication per EMAR (electronic medication administration record) orders. Identify client (resident), introduce yourself, explain what you are going to do and provide privacy. Review the six rights of medication administration. 1) medication 2) route 3) time 4) client 5) dosage 6) documentation wash hands, explain what the medication is and what you are giving it for. Remove medication from packages and put into medication cup. Hand medication cup to client and offer water or another liquid/other food source per care plan to facilitate swallowing. Ensure client has swallowed medication, document. R9's EMAR dated December 1, 2023, through December 31, 2023, included: -acyclovir (antiviral) 400 milligrams (mg) once daily in the morning -aspirin (heart health) 81 mg once daily in the morning	01760			

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01760	Continued From page 25 -cerovite tablet (vitamin) once daily -duloxetine (depression) 30 mg once daily -ferrous sulfate (supplement) 324 mg daily -hydrocort (inflammation) 10 mg daily -vitamin C (supplement/wound care) 500 mg twice a day -vitamin D 3 (supplement) 50 mcg daily -zinc sulfate (supplement) 50 mg daily. R9's prescriber's order dated September 16, 2023, included the above medications. On January 3, 2024, at 6:36 a.m., the surveyor observed licensed practical nurse (LPN)-B prepare R9's morning medication and place R9's medication into a medication cup. LPN-B took the medication cup and set the medication cup down my R9 who was seated at a table in the dining area. On January 3, 2024, at 6:41 a.m., LPN-B documented R9's medication as given. On January 3, 2024, at 6:52 a.m., the surveyor observed R9 seated at the dining room table with the medication cup containing medication next to him. On January 3, 2024, at 7:04 a.m., the surveyor observed R9 seated at the dining room table with the medication cup containing medication next to him. On January 3, 2024, at 7:13 a.m., the surveyor observed R9 going up the stairs holding onto a medication cup. On January 3, 2024, at 11:48 a.m., LPN-B stated she did "believe" R9's medication assessment stated staff was to administer R9's medication.	01760			

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01760	Continued From page 26 LPN-B said, "I reiterate with all staff" to make sure they (resident) take their medication. LPN-B added she was at "fault" when she administered R9's medication and did not watch R9 take his medication. On January 4, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-C stated R9 should have been watched during medication administration, adding medication times could be adjusted. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted the register nurse (RN) developed individualized medication plans that included verification that all medication, treatments and therapies were administered as prescribed and monitoring of medication use to prevent possible complications of adverse reactions. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790			

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01790	Continued From page 27 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790			

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01790	Continued From page 28 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-G) was trained by registered nurse (RN) and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 2, 2023, at 6:51 a.m., ULP-G stated she administers medications and assists with resident's cares. On January 3, 2023, at 7:23 a.m., the surveyor observed ULP-G take R6's blood pressure. ULP-G's employee record lacked evidence to indicate she had demonstrated competency to	01790			

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01790	Continued From page 29 provide medications to residents for unplanned times away from home. On January 3, 2023, at 2:48 p.m., clinical nurse supervisor (CNS)-C stated she had not done any unplanned medication training with any ULP since she started at the facility in August of 2021. The licensee's Medication Administration-Planned and Unplanned Time Away policy dated November 2019, noted the registered nurse had trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to clients (residents.) No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a	01880			

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01880	Continued From page 30 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: On January 2, 2024, at 12:41 p.m., the surveyor toured the facility with licensed practical nurse (LPN)-B, including a review of the medication refrigerator in the locked medication room. LPN-B stated the current temperature of the medication refrigerator was 30 degrees Fahrenheit (F). LPN-B stated the temperature of the medication refrigerator should be at 41 degrees. The Temperature log dated December 1, 2023, through December 29, 2023, indicated the temperature was monitored 22 of 29 opportunities. Of the 22 opportunities: -ten times the temperature was documented at 30 degrees -12 times the temperature was documented at 32 degrees -two times "yes" was documented. The medication refrigerator contained: -five unopened Tresiba (long acting) 100 units/milliliter (ml) insulin pens for R4 -one unopened Lantus (long acting) 100 units/ml insulin pen for R1 -four unopened Humalog (short acting) 100 units/ml insulin pens for R1. On January 2, 2024, at 12:41 p.m., clinical nurse supervisor (CNS)-C confirmed the medication refrigerator temperature was not within correct	01880			

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01880	Continued From page 31 limits. CNS-C asked LPN-B to adjust the temperature on the medication refrigerator. The manufacturer's instructions for Tresiba insulin pens dated July 2022, store unopened Tresiba in the refrigerator at 36 degrees F to 46 degrees F in the original carton to protect from light. Do not freeze Tresiba. Do not use Tresiba if it had been frozen. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Humalog insulin pens dated April 2020, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Humalog to freeze. The licensee's Storage of Medications policy dated December 2019, noted medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890			

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01890	Continued From page 32 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 with legible information including the expiration date for time sensitive medications for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 2, 2024, at 12:47 p.m., the surveyor toured the facility with licensed practical nurse (LPN)-B, including a review of the locked medication cart. LPN-B observed and confirmed the following: -one opened bottle of latanoprost 0.005% ophthalmic solution (glaucoma medication) did not have a label which indicated the date the bottle of latanoprost had been opened and when the bottle of solution would expire for R2. On January 2, 2023, at 12:51 p.m., clinical nurse supervisor (CNS)-C stated R2's latanoprost eye solution should have been dated with an opened and an expiration date.	01890			

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01890	Continued From page 33 The manufacturer's instructions for latanoprost eye drops dated August 15, 2023, directed eye drops could be used for up to six weeks when stored at room temperature, under 77 degrees Fahrenheit. The licensee's Storage of Medications policy dated December 2019, noted medications shall be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910			

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01910	Continued From page 34 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2024, at 12:17 p.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included hypertension (HTN-high blood pressure), diabetes, and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs.) R1's record lacked a service plan. R1's registered nurse (RN) assessment dated September 25, 2023, noted: -resident required assist with medication administration	01910			

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01910	Continued From page 35 -trained medication staff to administer all medications. R1's Medication Administration Record (MAR) for November 5, 2023, indicated R1 received the following medications: -cerovite tablet for seniors daily -ferosul 325 milligrams (mg) (anemia/low iron in body) daily -furosemide (CHF) 40 mg daily -Humalog Kwikpen (fast acting insulin) 100 units/milliliter (ml) five units daily -metoprolol Tar 25 mg (heart) twice daily -pot chloride (supplement) 10 milliequivalents (mEq) daily -torsemide (water retention) 20 mg daily Lantus Solostar (long-acting insulin) 100 units/ml 14 units daily. R1's provider orders dated November 5, 2023, included the above medications. R1's Discharge Summary dated November 16, 2023, noted R1 was discharged on November 16, 2023, noted: - reason: needed higher level of care -status of medications upon discharge: medications sent home with family: medications sent with daughter. R1's record did not include documentation for the disposition of the above noted medications to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On January 3, 2024, at 2:52 p.m., CNS-C stated R1's record lacked the required content for the	01910			

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NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES ASSISTED			STREET ADDRESS, CITY, STATE, ZIP CODE 409 13TH AVENUE TWO HARBORS, MN 55616		
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01910	Continued From page 36 disposition of medications noted above. On January 4, 2024, at 12:29 p.m., CNS-C stated the licensee was not able to produce records for anyone who had a discharged medication record. The licensee's Disposal of Medication policy dated August 1, 2021, noted upon disposition the assisted living provider must document in the record of disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940			

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01940	Continued From page 37 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R6, R4) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on January 2, 2024, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C and administrator (A)-H	01940			

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01940	Continued From page 38 confirmed the licensee provided treatment and therapy services to residents ANKLE-FOOT ORTHOSES (AFO/BRACE) R6 R6's diagnoses included diabetes without complications. R6's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident to put on her TED stockings (compression). Notify RN with any skin integrity concerns, redness, rash, increased swelling or complaints of pain or with any difficulty in application. On January 3, 2024, at 7:23 a.m., the surveyor observed ULP-G apply TEDs to R6's legs and AFO's to R6's feet and lower legs. On January 3, 2024, at 2:50 p.m., CNS-C stated instructions for AFO application would be in resident's room. CNS-C confirmed R6's record did not contain instruction for AFO, to include the procedure for contacting a registered nurse (RN) when a problem arose with AFO. BLOOD GLUCOSE MONITORING R4's diagnoses included diabetes without complications, hypertension (HTN/high blood pressure), and illness, unspecified. R4's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R4 received assist with ambulation, mandatory assessments, home health aide services, laundry, housekeeping, and linen change.	01940			

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01940	Continued From page 39 R4's December 1, 2023, through December 31, 2023, medication administration record (MAR) included: - 11:00 a.m.: blood glucose check, check resident's blood glucose with reader. R4's prescriber's order dated October 16, 2023, included: -blood glucose check, check resident's blood glucose with reader: 11:00 a.m., 4:00 p.m., 8:00 p.m. -Freestyle 2 reader (continuous blood glucose receiver use as directed.) R4's medication administration record (MAR) dated December 1, 2023, through December 31, 2023 included Freestyle blood glucose monitoring completed on December 1, 2023, December 3, 2023, December 15, 2023, December 29, 2023, December 30, 2023, by ULP-I. On January 3, 2024, at 11:37 a.m., the surveyor observed licensed practical nurse (LPN)-B check R4's blood glucose. LPN-B stated R4's blood glucose reader was not working. LPN-B escorted R4 to the medication room, gathered gloves, opened electronic MAR, unlocked medication cart, and removed a blood glucose meter. LPN-B used hand sanitizer, applied gloves, inserted a test strip into the blood glucose meter, used a lancet to collect a drop of blood. LPN-B wiped the first drop of blood off with a cotton ball and held the blood glucose test strip to the second drop of R4's blood to receive a reading of 193. R4's treatment plan lacked the procedure for contacting a registered nurse (RN) when a problem arose with R4's blood glucose monitoring.	01940			

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01940	Continued From page 40 On January 3, 2024, directly following the above observation LPN-B stated it was importance to have specific resident instructions in R4's record for blood glucose monitoring. On January 4, 2024, at approximately 1:00 p.m., CNS-C confirmed R4's record did not contain specific instructions for R4's blood glucose monitoring. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Mediation and Treatment Record policy dated November 2019, noted the RN would develop and would identify any specific client (resident) instructions regarding medication, treatments or therapy our agency staff would administer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:	01950			

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01950	Continued From page 41 (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) to demonstrate the ability to follow the procedure to perform the tasks using the FreeStyle blood glucose (sugar) monitoring system (system that measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of the upper arm), for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2024, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C and administrator (A)-H confirmed the licensee provided treatment and therapy services to residents.	01950			

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01950	Continued From page 42 R4's diagnoses included diabetes without complications, hypertension (HTN/high blood pressure), and illness, unspecified. R4's Assisted Living Agreement Addendum/service plan dated June 7, 2022, indicated R4 received assist with ambulation, mandatory assessments, home health aide services, laundry, housekeeping, and linen change. R4's prescriber's order dated October 16, 2023, included: -blood glucose check, check resident's blood glucose with reader: 11:00 a.m., 4:00 p.m., 8:00 p.m. -Freestyle 2 reader (continuous blood glucose receiver use as directed.) R4's December 1, 2023, through December 31, 2023, medication administration record (MAR) included: - 11:00 a.m.: blood glucose check, check resident's blood glucose with reader. R4's medication administration record (MAR) dated December 1, 2023, through December 31, 2023 included Freestyle blood glucose monitoring completed on December 1, 2023, December 3, 2023, December 15, 2023, December 29, 2023, December 30, 2023, by ULP-I. On January 3, 2024, at 11:37 a.m., the surveyor observed licensed practical nurse (LPN)-B check R4's blood glucose. LPN-B stated R4's blood glucose reader was not working. LPN-B escorted R4 to the medication room, gathered gloves, opened electronic MAR, unlocked medication cart, and removed a blood glucose meter. LPN-B used hand sanitizer, applied gloves, inserted a	01950			

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01950	Continued From page 43 test strip into the blood glucose meter, used a lancet to collect a drop of blood. LPN-B wiped the first drop of blood off with a cotton ball and held the blood glucose test strip to the second drop of R4's blood to receive a reading of 193. On January 4, 2024, at 11:42 a.m., CNS-C stated no training was done with ULPs for Freestyle blood glucose monitoring, adding "we did the finger stick training." The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced	01970			

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01970	Continued From page 44 by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R6, R8) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 2, 2024, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C and administrator (A)-H confirmed the licensee provided treatment and therapy services to residents. ANKLE-FOOT ORTHOSES (AFO/BRACE) R6 R6's diagnoses included diabetes without complications. R6's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident to put on her TED stockings (compression). Notify RN with any skin integrity concerns, redness, rash, increased swelling or complaints of pain or with any difficulty in application. On January 3, 2024, at 7:23 a.m., the surveyor	01970			

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01970	Continued From page 45 observed ULP-G apply TEDs to R6's legs and AFO's to R6's feet and lower legs. R8 R8's diagnoses included diabetes, cerebral infarction (disrupted blood supply and restricted oxygen supply/stroke,) hemiplegia hemiparesis affecting right domain (paralysis of one side of the body,) and osteoporosis (bones become brittle and fragile from loss of tissue.) R8's Assisted Living Agreement Addendum/service plan dated June 7, 2022, included: -assist resident with lower extremity dressing. She wants help getting her pants, socks, brace, and shoes on daily. On January 3, 2024, at 6:49 a.m., the surveyor observed ULP-G make R8's bed and then dress R8, with pants, socks, and right AFO. On January 3, 2024, at 8:08 a.m., the surveyor requested prescriber's order for R6 and R8, to include AFO orders. On January 3, 2024, at 8:11 a.m., clinical nurse supervisor (CNS)-C stated she was working on getting requested items, and had "looped" in the team. On January 3, 2024, at 10:10 a.m., the surveyor again requested prescriber's order for R6 and R8's AFOs. On January 4, 2024, at 9:25 a.m., CNS-C stated there was not an order for R6's AFO. CNS-C added R6 "can do it" (apply AFO.) On January 4, 2024, at 9:27 a.m., CNS-C stated	01970			

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01970	Continued From page 46 there was not an order for R8's AFO. CNS-C added, R8 "wanted" it done. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted treatments and therapies were administered as prescribed. In addition, The RN ensured that each client's (resident's) Individualized Treatment and or/Therapy Management Plan was kept up to date and consistent with prescriber's orders and with the needs and preferences of the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with an assistive device (consumer bed rail), for one of one resident (R8). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310			

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02310	Continued From page 47 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This resulted in an immediate correction order on January 3, 2024. The findings include: R8's diagnoses included diabetes, cerebral infarction (disrupted blood supply and restricted oxygen supply/stroke,) hemiplegia hemiparesis affecting right domain (paralysis of one side of the body,) and osteoporosis (bones become brittle and fragile from loss of tissue.) R8's assessment dated November 8, 2023, indicated R8's assistive devices included: glasses, dentures, walker, wheelchair. In addition, R8's assessment included: needed hands-on assist of one staff, due to limited range of motion with transferring and R8 was independent with mobility with aid of four wheeled walker. On January 3, 2024, at 6:51 a.m., the surveyor observed on R8's bed a single stationary U-shaped consumer bedrail on the upper left side of the bed in the upright position. R8 stated she used the rail on the left side of the bed because she slept on her left side and she needed the rail to turn around when in bed. On January 3, 2024, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated a bedrail assessment had not been completed for R8's consumer	02310			

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02310	Continued From page 48 bedrail as required. CNS-C stated she was not aware of the bedrail, adding she was not sure if or when family brought it in. On January 3, 2024, at 1:23 p.m., the surveyor and CNS-C observed R8's consumer bedrail. The bedrail frame was positioned between the mattress and the bed frame. The bedrail was not securely fastened to R8's bed. CNS-C stated R8 or R8's representative had not been provided information regarding the risks verses benefits for the use of a consumer bedrail. R8's record lacked a comprehensive assessment for the use of an assisted device (bedrail,) including installation and use of the device according to manufacturer's guidelines, lacked evidence of physical inspection of the bedrail and mattress for areas of entrapment, stability, correct installation of the device, and lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. R8's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The licensee's Assessment-Schedule Policy dated August 26, 2021, noted prior to installation or when reported to nurses. At least every 12 months a face-to-face assessment would be completed. The United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021, identified a recall involving adult portable bedrails that do not have safety retention straps to secure the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death.	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2024
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW SHORES ASSISTED			STREET ADDRESS, CITY, STATE, ZIP CODE 409 13TH AVENUE TWO HARBORS, MN 55616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 49 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30733	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2024
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02310	Continued From page 50 supervisor review on January 3, 2024, however noncompliance remains at a scope and level of three, isolated (G).	02310			

Type: Full
Date: 01/02/24
Time: 11:05:01
Report: 7980241001

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Waterview Shores Assisted
409 13th Avenue
Two Harbors, MN55616
Lake County, 38

Establishment Info:

ID #: 0038127
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2188348374
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.

4-500 Equipment Maintenance and Operation

4-501.114C3

**** Priority 1 ****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

SPRAY BOTTLE WAS ABOVE 400PPM, WATER WAS ADDED UNTIL SOLUTION WAS 400PPM. QUAT TEST STRIPS IN KITCHEN READ 400PPM BUT PAPER WAS YELLOW NOT WHITE AND NEED REPLACING. REQUEST NEW STRIPS THROUGH ECO LAB

Corrected on Site

2-100 Supervision

2-102.12FMN

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.

CHLORINE AND QUAT SANITIZER CONCENTRATIONS NEED TO BE CHECKED DAILY. CHLORINE IS CHECKED WEEKLY. ALWAYS CHECK CHLORINE AFTER REPLACING SANITIZER THE MACHINE WILL NEED TO BE PRIMED AND TESTED.

Comply By: 01/02/24

Surface and Equipment Sanitizers

Type: Full
Date: 01/02/24
Time: 11:05:01
Report: 7980241001
The Waterview Shores Assisted

Food and Beverage Establishment Inspection Report

Quaternary Ammonia: > 400 ppm at Degrees Fahrenheit
Location: Spray bottle
Violation Issued: Yes

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 189 Degrees Fahrenheit - Location: Sliced ham
Violation Issued: No

Process/Item: Steam Table
Temperature: 196 Degrees Fahrenheit - Location: Au gratin potatoes
Violation Issued: No

Process/Item: Steam Table
Temperature: 194 Degrees Fahrenheit - Location: Mixed vegetables
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Sausage gravy
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Mandarin oranges
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Pie
Violation Issued: No

Process/Item: Cooking
Temperature: 196 Degrees Fahrenheit - Location: Chicken pot pie
Violation Issued: No

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

Notes

1. HRD inspection with Cyndi Casey. Inspected assisted living kitchen. Food is made in the skilled nursing facility kitchen and transported in cambro boxes through a connected walkway to the assisted living kitchen. Food is held hot in steam table and served. Specialty menu item requests are cooked in this kitchen for residents. Kitchen has hand sink, prep sink, 3 compartment sink, chlorine dish machine with hood, up right Atosa 2 door refrigerator, steam table, range, oven and hood with fire suppression. The main walk in freezer and refrigerator along with dry storage are in the skilled nursing kitchen.
2. The Beamnova ice maker is approved since food service is same day service ANSI equipment is not required.
3. Employee illness procedures were discussed. Any employee with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop, illness is recorded in the log.

Type: Full
Date: 01/02/24
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The Waterview Shores Assisted

Food and Beverage Establishment Inspection Report

Page 3

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

I acknowledge receipt of the MDH inspection report number 7980241001 of 01/02/24.

Certified Food Protection Manager Mary Driscoll-Ault

Certification Number: FM 86336 Expires: 10/28/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kathleen, Robert Goodrich
Cook, Interm Culinary Director

Signed: Sara Bents

Sara Bents
Environmental Health Specialist
Duluth
218-302-6184
sara.bents@state.mn.us

Report #: 7980241001		Food Establishment Inspection Report							
 MDH 11 E Superior Street Duluth		No. of RF/PHI Categories Out		2		Date 01/02/24			
		No. of Repeat RF/PHI Categories Out		0		Time In 11:05:01			
		Legal Authority MN Rules Chapter 4626				Time Out			
The Waterview Shores Assisted		Address 409 13th Avenue		City/State Two Harbors, MN		Zip Code 55616		Telephone 2188348374	
License/Permit # 0038127		Permit Holder		Purpose of Inspection Full		Est Type		Risk Category	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item									
Mark "X" in appropriate box for COS and/or R									
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation									
Compliance Status				COS		R			
Supervision									
1 ☒ IN ☐ OUT				PIC knowledgeable; duties & oversight					
2 ☒ IN ☒ OUT N/A				Certified food protection manager, duties					
Employee Health									
3 ☒ IN ☐ OUT				Mgmt/Staff;knowledge,responsibilities&reporting					
4 ☒ IN ☐ OUT				Proper use of reporting, restriction & exclusion					
5 ☒ IN ☐ OUT				Procedures for responding to vomiting & diarrheal events					
Good Hygienic Practices									
6 ☒ IN ☐ OUT N/O				Proper eating, tasting, drinking, or tobacco use					
7 ☒ IN ☐ OUT N/O				No discharge from eyes, nose, & mouth					
Preventing Contamination by Hands									
8 ☒ IN ☐ OUT N/O				Hands clean & properly washed					
9 ☒ IN ☐ OUT N/A N/O				No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed					
10 ☒ IN ☐ OUT				Adequate handwashing sinks supplied/accessible					
Approved Source									
11 ☒ IN ☐ OUT				Food obtained from approved source					
12 ☐ IN ☐ OUT N/A ☒ N/O				Food received at proper temperature					
13 ☒ IN ☐ OUT				Food in good condition, safe, & unadulterated					
14 ☐ IN ☐ OUT ☒ N/A N/O				Required records available; shellstock tags, parasite destruction					
Protection from Contamination									
15 ☒ IN ☐ OUT N/A N/O				Food separated and protected					
16 ☐ IN ☒ OUT N/A				Food contact surfaces: cleaned & sanitized		X			
17 ☒ IN ☐ OUT				Proper disposition of returned, previously served, reconditioned, & unsafe food					
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation									
				COS		R			
Safe Food and Water									
30 ☒ IN ☐ OUT N/A				Pasteurized eggs used where required					
31 ☐ IN ☐ OUT				Water & ice obtained from an approved source					
32 ☐ IN ☐ OUT ☒ N/A				Variance obtained for specialized processing methods					
Food Temperature Control									
33 ☐ IN ☐ OUT				Proper cooling methods used; adequate equipment for temperature control					
34 ☐ IN ☐ OUT N/A ☒ N/O				Plant food properly cooked for hot holding					
35 ☐ IN ☐ OUT N/A ☒ N/O				Approved thawing methods used					
36 ☐ IN ☐ OUT				Thermometers provided & accurate					
Food Identification									
37 ☐ IN ☐ OUT				Food properly labeled; original container					
Prevention of Food Contamination									
38 ☐ IN ☐ OUT				Insects, rodents, & animals not present					
39 ☐ IN ☐ OUT				Contamination prevented during food prep, storage & display					
40 ☐ IN ☐ OUT				Personal cleanliness					
41 ☐ IN ☐ OUT				Wiping cloths: properly used & stored					
42 ☐ IN ☐ OUT				Washing fruits & vegetables					
Food Recalls:									
Person in Charge (Signature)									
Date: 01/03/24									
Inspector (Signature) <i>Sara Bonts</i>									