



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

August 4, 2023

Licensee
Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN 56472

RE: Conditional License Number 409783
Health Facility Identification Number (HFID) 34980
Project Number(s) SL34980015

Dear Licensee:

On July 26, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed March 24, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective August 4, 2023.

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.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 24, 2023, survey.

The details of the violations noted at the time of this follow-up survey completed on July 26, 2023 (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. §§ 144A.43 to 144A.482, no immediate fines are assessed.

Also, at the time of this follow-up survey completed on July 26, 2023, we identified the following violation(s):

1370-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Person-144g.61 Subd. 2 (b)

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.

DOCUMENTATION OF ACTION TO COMPLY

Per 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).

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 the 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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit

Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

A handwritten signature in black ink that reads "Maria King". The signature is written in a cursive, flowing style.

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34980	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/26/2023
NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472			
(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: Project SL34980015-1 On July 24, 2023, through July 26, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 24, 2023. At the time of the survey, there were 33 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	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

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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: No further action required.	{0 480}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	01370			

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01370	Continued From page 2 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-S) received the required training/competency testing. 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	01370		

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01370	Continued From page 3 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-S was hired to provide direct care services and assisted living services for the licensee's residents on March 21, 2023. On July 25, 2023, at 8:45 a.m., the surveyor observed ULP-S administer R31's morning medications and insulin. ULP-S's employee record lacked evidence of demonstrated competency in the following areas: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -training on fall prevention; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and -understanding appropriate boundaries between staff and residents and the resident's family. On July 26, 2023, at 11:50 a.m., executive director/registered nurse (ED/RN)-B stated ULP-S had not completed the above identified training. The licensee's Training and Competency Evaluations for ULP policy dated August 1, 2021, indicated when a RN or Licensed Health Professional delegates tasks, they must make certain the prior to the delegation, the ULPs are trained in the proper methods to perform the tasks or procedures for each resident and are	01370			

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01370	Continued From page 4 able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULPs shall include; -training on basic infection control; including blood-borne pathogens; -procedure for a clean and safe, uncluttered home environment; and -training on "Professional Boundaries for Care Givers", which include communication skills, preserving the dignity of the resident, showing respect for the resident, the resident's preferences, cultural background, and understanding appropriate boundaries between staff and resident's and the resident's family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and	01380			

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01380	Continued From page 5 (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-S) received the required training/competency testing. 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-S was hired to provide direct care services and assisted living services for the licensee's residents on March 21, 2023. On July 25, 2023, at 8:45 a.m., the surveyor observed ULP-S administer R31's morning medications and insulin. ULP-S's employee record lacked evidence of training and/or demonstrated competency in the following areas: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident.	01380			

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01380	Continued From page 6 On July 26, 2023, at 11:50 a.m., executive director/registered nurse (ED/RN)-B stated ULP-S had not completed the above identified training. The licensee's Training and Competency Evaluations for ULP policy dated August 1, 2021, indicated when a Registered Nurse (RN) or Licensed Health Professional delegates tasks, they must make certain that prior to the delegation, ULPs are trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULPs shall include: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to the RN, nurse and Assisted Living Director according to policy; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
{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	{01760}			

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{01760}	Continued From page 7 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 one of two unlicensed personnel (ULP-S) followed registered nurse (RN) written instructions for the administration of insulin pens and one of two ULP (ULP)-M followed RN written instructions for the administration of inhalers. 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: R31 R31' s' prescriber's orders dated December 8, 2022, included Lantus insulin 35 units in the morning and Novolog insulin 10 units with meals. R31's RN written instructions for insulin administration were as follows: -wash hands and apply gloves, pull pen cap straight off. -check the liquid in the pen, should be clear and	{01760}			

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{01760}	Continued From page 8 colorless; -wipe top of pen with alcohol swab; -always use a new needle for each injection; -push the capped needle straight onto the pen and twist the needle on until tight; -pull off outer cap; -priming your pen; hold the pen with needle point up, turn the dose selector to select 2 units; -hold the pen with the needle point up; -press and hold dose button until dose counter show "0"; -0 must line up with the dose pointed; -a drop of liquid should be seen at the needle tip. If you do not see a drop repeat above steps. If you do not see a drop after 3 tries, change the needle and try again; -turn dose selector to select the number of units you need injected; -the dose pointer should line up with your dose. If you select the wrong dose you can turn the dose forward or backward to the correct dose; -even numbers are printed on the dial, the odd numbers are shown as lines; -a second HHA (ULP) or licensed nurse will check the 6 rights; -if correct second staff will initial in the co-check space on the MAR (medication administration record). On July 25, 2023, at 8:45 a.m., the surveyor observed ULP-S administer R31's Lantus insulin. ULP-S performed the following steps: -wash hands and apply gloves, pull pen cap straight off. -check the liquid in the pen, should be clear and colorless; -push the capped needle straight onto the pen and twist the needle on until tight; -pull off outer cap; -primed the pens by turning the dose selector to	{01760}			

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{01760}	Continued From page 9 select 2 units: -turn dose selector to 35 units; -checked the dose with ULP-F; -both ULP-S and ULP-F documented their initials in R31 electronic medication administration record (EMAR); -ULP-S administered R 31's Lantus Insulin. -removed needle, discarded needle in appropriate container, removed glove, washed hands, and documented the administration of R31's insulin in R31's EMAR. ULP-S did not wipe the top on the pens with a alcohol wipe prior to putting the needle on the pens. On July 25, 2023, at 9:00 a.m., ULP-S stated she was not aware of the need to wipe off the top of the pens with alcohol prior to putting the needle on the pens. On July 25, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-J stated ULP were trained to wipe the top of the insulin off with a alcohol wipe prior to putting the needle on the pens. R8 R8's prescriber orders dated March 23, 2023, included Albuterol HFA 90 micrograms (mg) inhale two (2) puffs by mouth daily for shortness of breath. R8's July 2023, Medication Administration Summary indicated written instructions for Albuterol HFA inhaler included to provide the opportunity to rinse mouth. On July 25, 2023, at 7:57 a.m., the surveyor observed ULP-M administer R8's Albuterol Sulfate HFA inhaler. ULP-M shook the inhaler,	{01760}			

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{01760}	Continued From page 10 instructed R8 to take a breath in, administered one puff of the inhaler, and instructed to hold breath for five (5) to 10 seconds then release breath. ULP-M waited one minute before administering the second puff of the inhaler. After administration, ULP-M did not instruct R8 to rinse mouth after the use of the inhaler. Immediately following the medication administration, ULP-M documented in R8's medication administration record (MAR) medication was administered. ULP-M reviewed written instructions for the use of the inhaler in R8's MAR with surveyor which indicated to provide the opportunity to rinse mouth. ULP-M stated R8 was not offered to rinse mouth his after using the inhaler. On July 25, 2023, at 10:55 a.m., clinical nurse supervisor (CNS)-J stated staff were trained on inhaler administration and should be following the steps written instructions on the residents MAR. The licensee's Delegated Nursing Services policy dated August 1, 2021, indicted when medication management services were delegated to the ULP, the RN must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. The licensee's Discus Inhaler Administration policy dated August 1, 2021, indicated to instruct resident to rinse mouth with water and to spit the water out when done. No further information provided.	{01760}			
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	{01880}			

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{01880}	Continued From page 11 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 reviewed, the licensee failed to ensure R4's medications were stored in the locked medication cart. 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 July 25, 2023, at 7:00 a.m., the surveyor and unlicensed personnel (ULP)-R entered R4's room. The surveyor observed a bottle of Fluticasone nasal spray, Muro-128% eye drops, Brimonidine 0.2%, and Latanoprost eye drops, sitting on the dining table in R4's room. ULP-R stated R4 administers his own eye drops. ULP-R stated staff are to bring R4's the bottles of eye drops and nasal spray to the R4, R4 administers the medications, and then staff are to return the eye drops and nasal spray bottles to the locked medication cart. ULP-R stated the night staff must not have returned the medications to the medication cart. R4's Clinical Update Assessment dated July 22, 2023, indicated R4 was able to administer his	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34980	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/26/2023
NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472			
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{01880}	Continued From page 12 own eye drops and nasal spray and all medications are to be stored in the locked medication cart. On July 25, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-J stated R4's eye drops and nasal stray were to be returned to the locked medication cart after R4 administers the medications. The licensee's Storage of Medication Policy dated August 1, 2021, indicated medications would be stored consistent with each individual Assisted Living Residents' medication management plan and service plan. In addition, medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). The licensee's Storage of Medication Policy dated August 1, 2021, indicated medications would be stored consistent with each individual Assisted Living Residents' medication management plan and service plan. In addition, medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided.	{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 label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to monitor for expired medications being managed and stored by the licensee. 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: During entrance conference on July 24, 2023, at 1:33 p.m., executive director/registered nurse (ED/RN)-B stated the nurse completed weekly audits on all medication carts looking for dates on time-sensitive medications and expired medications. On July 24, 2023, at 3:30 p.m., the surveyor observed the west medication cart in the unsecured building with unlicensed personnel (ULP)-S confirming the following. -one tube of triple antibiotic ointment, with an expiration date of May 2023; and -one tube of E-Z lubricating jelly, with an expiration date of July 2020. On July 24, 2023, at 3:30 p.m., clinical nurse specialist (CNS)-J stated the above medications were stock supply, and both medications had expired. CNS-J removed the medications from	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 14 the medication cart. CNS-J stated she would order a new stock supply. No further information was provided.	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R6) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 15 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: The licensee's Discharged Resident/Client Roster dated July 24, 2023, indicated R12 was admitted on September 22, 2022, and discharged on July 13, 2023, to the community. R12's diagnoses included alcohol abuse.. R12's discharge summary dated July 13, 2023, indicated R12 received medication management services. The discharge summary included a list of all the medications R12 was receiving and were given to R12. The list of medications included the name of the medications, strength, prescription number, to whom the medications were given, the date of disposition, and the name of staff involved in the disposition. R12's discharge summery did not include the quantity of each medication. On July 25, 2023, at 2:32 p.m. clinical nurse supervisor (CNS)-J stated the R12 discharge summary did not include the quantity of each medication given to R12. The Licensee's Disposal of Medication policy dated August 1, 2021, indicated upon disposition, the licensee must document in the resident medication destruction record the disposition of the medication including:	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 16 -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.	{01910}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

May 9, 2023

Licensee
Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN 56472

RE: Conditional License Number 409783
Health Facility Identification Number (HFID) 34980
Project Number(s) SL34980015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 24, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **August 7, 2023**.

LICENSING ORDERS

The enclosed State Form documents the state licensing 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$9,000. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0470 - 144g.41 Subd. 1 - Minimum Requirements = \$3,000.00

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement = \$3,000.00

St - 0 - 2370 - 144g.91 Subd. 9 - Right To Come And Go Freely = \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144G.**

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division

Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

CONDITIONAL LICENSE ISSUED:

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

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

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Shiloh Assisted Living will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Shiloh Assisted Living must provide MDH:
 - i. A list of the names and birthdates of any individuals Shiloh Assisted Living is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Shiloh Assisted Living will contract with an RN to provide consultation concerning all resident(s) to whom Shiloh Assisted Living provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Shiloh Assisted Living. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Shiloh Assisted Living and MDH must review the RN’s credentials and approve the selection. Shiloh Assisted Living is responsible for the expense of the contract with the RN. The main purpose of the consultant is

to provide guidance to Shiloh Assisted Living in an effort to help Shiloh Assisted Living align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Shiloh Assisted Living will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Shiloh Assisted Living and the RN consultant about a change. Each report will be electronically submitted to Jessica Chenze, Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:
 - i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by MDH or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Shiloh Assisted Living to correct the violations cited during the survey as well as to determine the overall practice of Shiloh Assisted Living in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

- g. Corrective Action Plan:** Shiloh Assisted Living will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
- i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

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

MDH will determine if Shiloh Assisted Living is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Shiloh Assisted Living is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Shiloh Assisted Living's assisted living facility license, and Shiloh Assisted Living will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Shiloh Assisted Living is not in substantial compliance, MDH may take additional enforcement action against Shiloh Assisted Living, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 17, the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

Shiloh Assisted Living

May 9, 2023

Page 6

If you have any questions, please contact Jessica Chenze directly at: 218-332-5175.

Sincerely,

A handwritten signature in black ink that reads "Maria King". The signature is written in a cursive style with a large, stylized "M" and "K".

Maria King, RN
Division Director

**Minnesota Department of Health
Health Regulation Division**

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34980	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2023
NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472		
(X4) ID PREFIX TAG 0 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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: SL34980015 On March 20, 2023, through March 24, 2023,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 38 active residents receiving services under the Assisted Living Dementia Care license. Immediate correction orders were identified on March 21, 2023 and March 22, 2023, issued for SL34980015, tag identification 0470, 2070 and 2310. On March 22, 2023, the immediacy of correction orders 0470 and 2070 were removed, however non-compliance remained at a scope and level of I. On March 23, 2023, the immediacy of correction order 2310 was removed, however	ID PREFIX TAG 0 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Minnesota Department of Health is documenting the State Licensing 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.	(X5) COMPLETE DATE

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 250		

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NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472		
(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
0 250	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 20, 2023, at 10:50 a.m., registered nurse (RN)-B stated she was familiar with current assisted living laws and regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults.	0 250			

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0 250	Continued From page 4 - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally	0 250			

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0 250	Continued From page 5 responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-L on May 28, 2021. The licensee had an assisted living license issued on January 1, 2023, with an expiration date of December 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified,	0 250			

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0 250	Continued From page 6 managed, and communicated to staff and other health care providers as appropriate; (4) orientation to and implementation of the assisted living bill of rights; (5) infection control practices; (6) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (7) medication and treatment management; (8) delegation of tasks by registered nurses or licensed health professionals; On March 23, 2023, at approximately 4:00 p.m., O-L confirmed the licensee provided Assisted Living with Dementia license but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0330, 0450, 0470, 0480, 0485, 0510, 0630, 0650, 0660, 0680, 0800, 0810, 1420, 1470, 1620, 1640, 1760, 1830, 1880, 1890, 1910, 1950, 1960, 1970, 2040, 2070, 2170, 2310, 2370, 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the	0 330			

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0 330	Continued From page 7 department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information for one of two medication refrigeration temperature logs (secured building). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 20, 2023, at 3:06 p.m., the evaluator observed unlicensed personnel (ULP)-M and ULP-Q count the scheduled pre-filled morphine syringes in the medication refrigerator on Upper Dakota (secured unit). The evaluator requested to review the recorded fridge temperatures. ULP-M stated she was unable to find the temperature logs for March 2023. On March 20, 2023, at 3:23 p.m., the evaluator informed licensed assisted living director (LALD)-A that ULP-M was unable to locate the	0 330			

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0 330	Continued From page 8 temperature logs for March 2023 for the medication refrigerator located on the secured unit. The evaluator requested three months of temperature logs to review. LALD-A stated night staff was responsible for recording the medication refrigerator temperatures. LALD-A further stated she checked the temperature logs daily to make sure they were being recorded and if there was not temperature recorded, LALD-A would check and record the fridge temperatures. On March 20, 2023, at approximately 4:00 p.m., the secured house medication refrigerator temperatures were provided for December 2022, through March 2023, and later reviewed by the evaluator. The written recorded fridge temps for March 2023, provided were documented daily with recorded temperatures; however, the entries for the temperatures, staff initials and action codes appeared to be the same handwriting for all entries including the different staff initials. On March 20, 2023, at 4:22 p.m., the evaluator questioned LALD-A of when and who completed the entries for March 2023, fridge temperatures. LALD-A stated she filled in all the entries for March 2023, including the entries of other employees' initials. LALD-A confirmed the fridge temperatures were not previously recorded for March 2023 and altered the document after the evaluator requested the medication fridge temperature logs. LALD-A apologized for altering documents. On March 23, 2023, at 9:20 a.m., registered nurse (RN)-B stated it was expectation of staff to provide the original documents requested by the evaluator without making any alterations. No further information provided.	0 330			

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0 330	Continued From page 9	0 330		
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: Based on observation, interview and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for one out of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 450		

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0 450	Continued From page 10 R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1's services included toileting reminder fourteen times daily, dressing assist, AM (morning) and PM (evening), transfer assistance three times daily, and behavior management three times daily. R1's assessment dated January 11, 2023, indicated: -R1 was dependent on the assist of two staff multiple times in a 24-hour period with toileting; -resident wears briefs; and -R1 needed two people to transfer, assist of two staff with transfers and a transfer belt. May use sit to stand lift with assist of two if resident feels weak. R1's RTask (electronic documentation system) other personal needs- overnight, daily, instructions, active on March 6, 2023, indicated, "please change the soaker pad under resident EACH TIME SHE USES THE BED PAN DURING THE NIGHT. PLEASE CHANGE THE SOAKER PAD EVEN IF IT IS NOT WET OR SOILED." On March 20, 2023, at approximately 4:20 p.m., R1 started to tear up about "having to use" a bedpan at night. R1 stated she did not have a choice regarding the use of a bedpan. R1 added there was only one staff working the night shift and she needed two staff to assist with her transfer. On March 21, 2023, at 6:39 a.m., unlicensed	0 450			

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0 450	Continued From page 11 personnel (ULP)-G stated R1 wanted to get up during the night. ULP-G stated, R1 was not able to get up during the night. ULP-G added, she could not get R1 out of bed, "I am by myself. I help her the best I can." On March 21, 2023, at approximately 6:45 a.m., ULP-G stated R1 didn't understand she cannot get R1 up. ULP-G added R1 complains she is wet when she is dry. ULP-G stated she put a blanket under R1 to lay on, "to try that." On March 21, 2023, at approximately 7:30 a.m., the evaluator observed R1 laying in a hospital bed wearing a night gown laying on a blanket. R1 did not have a brief on. ULP-G and registered nurse (RN)-J assisted R1 out of bed using a Best Care sit to stand (mechanical lift.) On March 21, 2023, at 12:53 p.m., RN-B stated the assisted living was a business and the rooms needed to be filled. RN-B stated the night shift was the only shift that was short staffed, and the licensee has been trying to find staff to fill the float position on the night shift. On March 21, 2023, at 12:59 p.m., RN-B stated she asked R1 if she would use a bedpan at night. Per RN-B, R1 agreed to use a bed pan, as did R1's family. R1's Minnesota Bill of Rights for Assisted Living Residents authenticated on December 20, 2022, indicated 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. In addition, residents have the right to receive health care and other assisted living services with continuity from people that are	0 450			

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0 450	Continued From page 12 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	0 450			
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470			

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0 470	Continued From page 13 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the facility had sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's assessments and served plans on a 24- hour per day basis. This had the potential to affect all residents, staff and visitors. In addition, the licensee failed to ensure the staffing schedule was posted as required in one of two buildings (secured building). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order identified on March 21, 2023. The findings include: On March 20, 2023, at approximately 11:15 a.m., during the entrance conference registered nurse (RN)-B stated the staffing plan combined the two houses, Shiloh (non-secure assisted living) and Dakota (secure memory care unit). Each house staffed two ULP on day shift and afternoon shift, and each house staffed one ULP overnight. On March 21, 2023, at 6:39 a.m., unlicensed	0 470			

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0 470	Continued From page 14 personnel (ULP)-G stated this "house"[Shiloh] had three residents whom required two staff for assist with transfers with mechanical lifts. ULP- G stated R7 "can't talk, can't complain", R3 "wants to sleep", and R1 "she has a bed pan in there [her room]. R1 uses a lift requiring two staff, can't get her up." R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily, dressing assist, blood glucose checks four times daily, blood pressure monitoring daily, special dressing three times daily, oxygen saturations twice daily, pulse monitoring twice daily, temperature twice daily, toileting reminder fourteen times daily, transfer assistance three times daily, assistance with bathing twice weekly, behavior management three times daily, and housekeeping services. On March 20, 2023, at 1:07 p.m., the staffing plan was reviewed with licensed assisted living director (LALD)-A. LALD-A stated each house (Shiloh and Dakota) have two ULPs working on days, two ULPs working on afternoons, and one ULP working in each house daily. On March 20, 2023, at approximately 4:20 p.m., R1 started to tear up about "having to use" a bedpan at night. R1 stated she did not have a choice regarding the use of a bedpan. R1 added there was only one staff working the night shift and she needed two staff to assist with her transfer.	0 470			

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0 470	Continued From page 15 On March 21, 2023, at 9:25 a.m., the evaluator observed clinical nurse specialist (CNS)-C and RN-B transfer R1 from the toilet and into a wheelchair using a sit to stand (mechanical lift.) On March 21, 2023, at approximately 1:00 p.m., CNS-C stated she "stepped down the end of October. I just came back one and a half weeks ago. CNS-C confirmed "it has been a while" since the staff plan was reviewed. CNS-C added she reviewed the plan last year. CNS-C confirmed the staffing plan had not been reviewed as required. On March 21, 2023, at 12:53 p.m., RN-B stated the assisted living was a business and the rooms needed to be filled. RN-B stated the night shift was the only shift that was short staffed, and the licensee has been trying to find staff to fill the float position on the night shift. On March 21, 2023, at 12:59 p.m., RN-B stated she asked R1 if she would use a bedpan at night. Per RN-B, R1 agreed to use a bed pan, as did R1's family. The licensee's Staffing Plan policy dated August 29, 2019, indicated the purpose of this policy was to provide guidance on staffing in assisted living communities operated by [name of company]. The plan must be reviewed by the CNS bi-annually or as resident acuity requires. This policy included: - community name, Shiloh - Dakota will operate with four (4) A.M. (day) staff; - community name, Shiloh - Dakota will operate with four (4) P.M. (evening) staff; and - community name, Shiloh -Dakota will operate with two (2) NOC (night) day. No further information was provided.	0 470			

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NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472		
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0 470	Continued From page 16 TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyors' on-site observation and review by evaluation supervisor on March 22, 2023, however, non-compliance remains at a scope and level of three, widespread (I). STAFF SCHEDULED POSTED On March 20, 2023, at approximately 1:00 p.m., the evaluator did not observe a posted staff scheduled in the secured building. On March 20, 2023, at 1:07 p.m., licensed assisted living director (LALD)-A confirmed there was no staff schedule posted in the secured building. LALD-A stated she was told she did not need to post the staffing schedule in the secured unit. LALD-A stated in the past "everyone" had to stop at the "other" (assisted living) building for Covid screening. LALD-A added, "but that is no longer the case." The licensee's Staffing policy dated November 1, 2019, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a community or campus, accessible to staff, residents, volunteers, and the public. The community shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 480	Continued From page 17	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 included document titled, Food and Beverage Establishment Inspection Report dated March 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485			

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0 485	Continued From page 18 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents on the secured unit. This had the potential to affect all 18 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 20, 2023, at approximately 1:00 p.m., during a tour of the Upper Dakota (secured unit)	0 485		

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0 485	Continued From page 19 the evaluator did not observe a menu posted. The resident roster for the secured unit included eighteen residents. One (1) resident of eighteen had a primary diagnosis of dementia. On March 20, 2023, at 1:06 p.m., licensed assisted living director (LALD)-A stated the residents take the menu down, adding "we normally do have it posted." On March 21, 2023, at 8:22 a.m., on secured unit the evaluator observed the menu was only posted for lunch and dinner on a piece of paper for March 21, and March 22, 2023. The posted menu lacked meals for the week. On March 21, 2023, at 8:44 a.m., dietary (D)-P stated weekly menus were not posted or provided to the residents in the secured unit and were provided and posted for the residents in the assisted living. On March 21, 2023, at 8:48 p.m., LALD-A stated weekly menus were not provided to the residents in the secured unit but would provide a menu if the resident requested one. LALD-A stated all the residents on the secured unit had dementia and would not care to have a menu or wouldn't be able to read it. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510			

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0 510	Continued From page 20 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure infection control standards were followed by three of four unlicensed personnel (ULP)-E, ULP-F ULP-M, during personal cares for R2, R1, R11. In addition, ULP-F failed to ensure reusable equipment was cleaned in-between resident use. 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: PERSONAL CARES R2 On March 20, 2023, at approximately 2:15 p.m., the evaluator observed ULP-E assist R2 ambulate to R2's room. ULP-E donned (applied)	0 510			

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0 510	Continued From page 21 gloves and instructed R2 to walk to the bathroom and sit on the toilet. ULP-E pulled down R2's brief and checked the brief to see if the brief needed to be changed. ULP-E removed the brief R2 was wearing and applied a new brief, applied lotion to R2's legs, and wiped R2's peri area (perineum). ULP-E pulled up R2,'s brief and pants. ULP-E doffed (removed) gloves and placed them into a trash can. ULP-E removed the trash can liner and set it by R2's door. ULP-E walked with R2 to the common's area and directed him to sit in a chair. ULP-E returned to R2's room and picked up the trash and took it into a door marked laundry room. ULP-E went into a nursing office and got a plastic container which contained several packages of cigarettes. ULP-E took the plastic container and stood by a door. ULP-E gave five cigarettes to an unidentified resident. ULP-E did not complete hand hygiene at any point during the evaluator's observations. On March 20, 2023, at 2:40 p.m., ULP-E stated she did not wash her hands, she added she normally washes her hands but, "my mind is they {residents) are waiting to smoke." On March 20, 2023, at 2:50 p.m., registered nurse (RN)-B stated the expectation for hand hygiene included: hands should be washed, before and after any cares, services, and food. R1 On March 21, 2023, at approximately 7:30 a.m., the evaluator observed ULP-F with gloved hands place her right hand under a blanket R1 had been laying on. ULP-F stated the blanket was dry. R1 continued to state the area under her was wet. ULP-F doffed the glove from her right hand and placed her ungloved right hand under the blanket R1 had been laying on. ULP-F started to put the	0 510			

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0 510	Continued From page 22 glove she had removed from her right hand back on but stopped and got a new glove and placed it on her right hand. ULP-F left R1's room wearing gloves to get a Best Care sit to stand lift (mechanical lift). ULP-F and RN-J assisted R1 out of bed using the sit to stand lift and onto the toilet. RN-J assisted R1 with peri care and dressed R1's lower body with gloved hands. R1 was assisted into a wheelchair by ULP-F and RN-J. ULP-F removed R1's night gown and dressed R1's upper body. ULP-F doffed gloves and returned the sit to stand lift. ULP-F did not complete hand hygiene at any point during the evaluator's observations. On March 21, 2023, directly following the above observation, RN-J left the room. The evaluator did not observe RN-J complete hand hygiene at any point during the evaluator's observations. RN-J stated she was going to wash her hands and she was headed to a place to complete hand hygiene. On March 21, 2023, at 8:02 a.m., ULP-F confirmed she did not perform hand hygiene at any time during the above observation. ULP-F stated "I change gloves. I don't always wash my hands. Should wash hands in-between residents." ULP-F added she wears gloves, uses sanitizer two times and then washes her hands. On March 23, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-C confirmed hands should be washed between cares, before applying gloves and when gloves are removed. CNS-C added that is the way she trained staff. R11 On March 21, 2023, at 9:22 a.m., the evaluator observed ULP-M provide morning cares for R11.	0 510			

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0 510	Continued From page 23 ULP-M prepared a basin filled with clear water and a basin filled with soapy water. ULP-M donned gloves removed R11's shirt and washed R11's face and armpits. ULP-M put a clean shirt on R11, removed R11's urine soiled brief, washed R11's peri area and buttocks. Without changing gloves or performing hand hygiene, ULP-M applied R11's brief, put on socks, reached into her pocket to grab the walkie-talkie and summoned assistance for a transfer. Wearing the same pair of gloves, ULP-M assisted putting R11's pants on lower legs and waited for transfer assistance. At 9:32 a.m. ULP-I arrived in R11's room, to assist with R11's transfer with the use of a mechanical lift. Wearing the same pair of gloves, ULP-M operated the controls of the mechanical lift, ULP-I pulled up R11's pants and R11 was transferred into the wheelchair. ULP-M doffed gloves, tied garbage bag, placed a clean bag into the garbage can and assisted R11 into the bathroom. ULP-M washed hands and assisted providing oral care for R11. On March 21, 2023, at 9:44 a.m., ULP-M stated she should have changed gloves after providing R11's personal cares, before touching the walkie-talkie and dressing R11. ULP-M stated she forgot. On March 23, 2023, at 2:55 p.m., RN-J stated after providing peri cares, staff should change gloves, perform hand hygiene, put on a clean pair of gloves before proceeding dressing. RN-J stated staff should be working from clean to dirty during cares and change gloves in between. RN-J further stated staff should not be handling the walkie-talkies with soiled gloves. DISINFECTING EQUIPMENT BETWEEN USE On March 21, 2023, at approximately 7:20 a.m.,	0 510			

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0 510	Continued From page 24 the evaluator observed ULP-F take a blood pressure (BP) machine and SpO2 monitor out of the medication cart and take them to R10's room. ULP-F took R10's BP and oxygen level. ULP-F returned the BP machine and SpO2 monitor to the medication cart. The evaluator did not observe ULP-F clean the BP machine or the SpO2 monitor at any time during the observation. On March 21, 2023, at 8:04 a.m., ULP-F stated she usually cleans equipment before use. ULP-F added with "everyone calling me ... normally I do clean it when I bring it [equipment] back". On March 21, 2023, at 9:02 a.m., the evaluator observed ULP-F removed the BP machine from the medication cart. ULP-F took R11's BP. ULP-F returned the BP machine to the medication cart. On March 21, 2023, at 9:23 a.m., ULP-F confirmed she did not clean the BP machine before or after taking R11's BP. ULP-F added she had been trained to clean equipment before and after use. On March 23, 2023, at 11:17 a.m., CNS-C confirmed reusable equipment should be cleaned after each use. CNS-C added she trains ULPs to clean equipment before and after use. The licensee's Hand Washing policy dated August 1, 2021, indicated hand washing would be completed: -before, during, and after preparing food; -before eating food; -before and after caring for someone who is sick; -before and after treating a cut or wound; -after using the toilet; -after changing incontinent products or cleaning up after someone who has used the toilet;	0 510			

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0 510	Continued From page 25 -after blowing your nose, coughing, or sneezing; -and touching an animal or animal waste; -after handing pet food or pet treats; and -after touching garbage. The licensee's Gloves policy dated August 1, 2021, indicated gloves are to be worn whenever there may be direct contact between any employee and contaminated objects. the procedure to wear gloves is: wash hands, apply gloves to both hands, remove contaminated materials, place materials in proper receptacle, remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff or remaining glove and pull off, turning inside out. Dispose of in proper receptacle and rewashed hands. The licensee's Cleaning of Shared Medication Equipment dated August 1, 2021, indicated the community would implement and maintain processes to ensure all equable home care (assisted living) resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reuse. Commonly shared assisted living resident care equipment may include: stethoscopes, glucometers not limited to individual resident use, and mechanical lifts, etc. 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	0 630			

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0 630	Continued From page 26 (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) were developed to include the required content for four of four residents (R6, R17, R18, R24) who had exhibited inappropriate sexual behaviors toward others. 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: R6 R6's diagnoses included pedophilic disorder (disorder where there is a preference for sexual activity with a young adolescents), personality disorder and vascular dementia.	0 630			

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0 630	Continued From page 27 R6's IAPP dated February 8, 2023, indicated R6 had sexually inappropriate behaviors and was a registered sex offender. R6's IAPP identified R6 was at risk to abuse other vulnerable adults and plan of action included hourly safety checks and R6 wore an ankle bracelet monitored by the local police department. R6's IAPP lacked a plan of action to include risk to staff and visitors including children. R17 R17's diagnoses included bipolar and schizophrenia disorders. R17's IAPP dated January 23, 2023, indicated R17 had a history of being sexual inappropriate to staff and other residents. R17's plan of action included hourly safety check, redirection, and to remove R17 from the situation. R17's IAPP lacked a plan of action to include risk to staff and visitors. R18 R18's diagnoses included paraphilia (frequent, intense, sexually arousing fantasies or behaviors that involve inanimate objects, children or nonconsenting adults). R18's IAPP dated January 10, 2023, indicated R18 was a registered sex offender, has displayed inappropriate sexual conduct towards residents and staff. R18's plan of action included hourly safety checks, redirection and R18 was in a secured unit. R18's IAPP lacked a plan of action to include risk to staff and visitors including children. R24 R24's diagnoses included anxiety, depression, and alcoholism.	0 630			

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0 630	Continued From page 28 R24's IAPP dated February 24, 2023, indicated R24 had a history level two sex offender (non-violent sex crimes involving a minor). R24's plan of action included being in a secured unit and follow up by the local police department. R24's IAPP lacked a plan of action to include risk to staff and visitors including children. On March 23, 2023, at 9:05 a.m., registered nurse (RN)-B reviewed R6, R17, R18, and R24's IAPP and stated interventions for the resident's inappropriate sexual behaviors were for the residents to be in a secured unit and hourly safety check. RN-B confirmed the resident's IAPPs did not include interventions that were individualized for each resident's sexual behaviors and lacked interventions to reduce the risk of sexual abuse to other residents, staff, and visitors including children. RN-B further stated staff were trained in caring for residents with dementia but have not received specific training in caring for residents who were sex offenders or exhibited inappropriate sexual behaviors. The licensee's Vulnerable Adults Maltreatment, Communication, Prevention and Reporting Plan dated August 1, 2021, indicated each resident would have an Individual Abuse Prevention Plan (IAPP) which would be reviewed annually or with a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650			

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0 650	Continued From page 29 (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 the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	0 650			

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0 650	Continued From page 30 only occasionally). The findings include: ULP-F was hired on May 12, 2022, to provide direct care services to residents of the facility. On March 21, 2023, at 7:40 a.m., the evaluator observed ULP-F and registered nurse (RN)-J transfer R1 from bed to wheelchair using a Best Care sit to stand transfer device (mechanical lift). On March 22, 2023, at 12:56 p.m., clinical nurse supervisor (CNS)-C stated she verbally taught ULP-F the following: -documentation requirements for all services provided; -maintenance of a clean and safe environment; -training on the prevention of falls for providers working with the elderly or individuals at risk of falls, standby assistance techniques and how to perform them, and had ULP-F demonstrate skill; -medication exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating, -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of commonly used health technology equipment and assistive devices; -observation, reporting, and documenting of client status; -basic knowledge of body functions and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and	0 650			

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0 650	Continued From page 31 developmental needs of the resident. ULP-F's employee record did not include the above-mentioned training. On March 22, 2023, at approximately 1:22 p.m., CNS-C stated ULP-F's training was not done in the usual manner. CNS-C confirmed ULP-F's employee record did not contain evidence of "several training topics. " The licensee's Orientation & Training Policies dated August 1, 2021, indicated a registered nurse would determine what nursing services may be delegated to properly train and competency test unlicensed personnel. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such delegated tasks. Training and competency evaluations for all ULPs shall include: - charting/documentation weekly charting will be done on the first bath day of week, by unit rotating between all shifts, or as tasks are performed for all service provided, depend on paper charting or computer; - emergency situation policy provides direction on non-life-threatening change-in condition reporting requirements and life-threatening emergency reporting by calling of 911. All/any change-in-condition are required to be reported to the RN and assisted living director -ULP class included training on basic infection control, including blood-borne pathogens. This is an annual training requirement - procedure for a clean and safe, uncluttered home environment are reviewed with ULPs and monitored with supervisory visits; -ULP training included procedures for personal	0 650			

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0 650	Continued From page 32 hygiene and grooming, monitored with supervisory visits, which include; hair care and bathing, care and use of hearing aide, care of teeth, gums, and oral prosthetic devise, dressing and assisting with toileting; - training on completing incident reports, preventative interventions, and follow-up interventions; - training on standby assistance techniques, assist of one & two staff, use of walker, use of cane, and mechanical devices; -ULP training on medication procedures, treatment procedures, documentation, security of medications, and accountability for medications; - resident exercise group as part of activities scheduled; - training on basic nutrition, meal preparation, food safety, and assistance with eating; - training on preparation of modified diets as ordered by a licensed health professional, done with individual order changes; -ULP-training on Professional Boundaries for Care Givers, which include communication skills, preserving the dignity of the resident, showing respect for the resident, the resident's preferences, cultural background, and understanding appropriate boundaries between staff and residents and the resident's family; -ULP training on HIPAA, (Health Insurance Portably and Accountably Act) Resident Bill of Rights, confidentiality and privacy -ULP training on handing various emergency situations; -ULP training on commonly used heath technology equipment: blood pressure cuff, thermometer, oxygen saturation, oxygen, nebulizers, C-PA), etc. as appropriate; -training on observation, reporting, and documentation using current charting system and behavior charting suing separate charting forms;	0 650			

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0 650	Continued From page 33 -training basic knowledge of body functions & any changes in body functioning, injuries, or other observed changes that must be reported to the RN, nurse, and assisted living director according to policy; - recognizing physical, recording temperature, pulse, and respirations on vitals flow sheet; -emotional, cognitive, and developmental needs of the resident; -training on safe transfer techniques and ambulation; -training on range of motioning, positioning, and proper body alignment; -training on administering medications according to residents five (5) rights, medications for LOA (leave of absence), medication ordering and receiving, medication destruction, medication documentation, narcotic counting and documentation, etc; -training on treatments for resident as the specific treatment is ordered, including documentation. In addition, A copy of all education, training, and competency testing shall be kept in each staff personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660			

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0 660	Continued From page 34 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptom screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (unlicensed personnel (ULP)-H). 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: The facility's TB risk assessment dated May 12, 2022, determined the setting to be a low risk level and identified clinical nurse supervisor (CNS)-C	0 660			

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0 660	Continued From page 35 responsible for the licensee's TB infection control program. ULP-H started employment March 16, 2023. ULP-H's employee record lacked a current health history and symptom screening and a two-step TST or other evidence of TB screening such as a blood test. On March 21, 2023, at 7:35 a.m., the evaluator observed ULP-H training alongside ULP-M during the day shift in Upper Dakota House. ULP-H stated yesterday (March 20, 2023), was her first official day and would be shadowing other ULPs until she felt comfortable to work independently with the residents. On March 21, 2023, at 9:40 a.m., the evaluator observed ULP-H escort R11 to the dining room table for breakfast. On March 22, 2023, at 12:35 p.m. registered nurse (RN)-B stated ULP-H was a new hire and "ideally" should have completed a TB symptom screening and received the first step TST prior to working on the floor with residents. On March 22, 2023, at approximately 1:00 p.m., CNS-C confirmed ULP-H was a new hire and had not completed a TB symptom screening or received a first step TST prior to working. CNS-C further stated ULP-H's TB paperwork was on her desk to be completed. The licensee's TB Plan, Staff Screening, Resident Assessment policy dated August 1, 2021, indicated baseline screening was required for all ULP's including current symptoms, TB history and testing at the time of hire.	0 660			

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0 660	Continued From page 36 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 37 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an exit diagram in one of three buildings (Shiloh 2) prominently. This had the potential to affect all Shiloh 2 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 20, 2023, at 11:17 a.m., the evaluator asked for the licensee's EPP, which was provided to and later reviewed by the evaluator. The licensee's EPP failed to include the following:	0 680			

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0 680	Continued From page 38 - current, all-hazards approach facility assessment; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; and - procedures for tracking of staff and patients. On March 20, 2023, at 12:02 p.m., registered nurse (RN)-B verified Shiloh 2 did not have an exit diagram posted. RN-B added there was only one resident currently in that building. On March 20, 2023, at appropriately 4:00 p.m., licensed assisted living director (LALD)-A confirmed the facility's EPP was not fully developed as required. LALD-A stated she "thought" the risk assessment might be located in the secured unit's EPP binder confirming there was no risk assessment in the assisted living binder. LALD-A added she would look "on-line" for the completed risk assessment. On March 23, 2023, at approximately 9:15 a.m., agent (A)-N reviewed the risk assessment that had been added to the assisted living EPP binder. A-N stated the risk assessment was not complete. The licensee's Disaster Planning and Emergency Preparedness Plan dated November 1, 2019, indicated: this community would have in place a general emergency preparedness plan, that is in alignment with community's requirement to also comply with CMS Appendix Z. In addition, this community would post emergency exit diagrams on each floor of the community. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 680			

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0 680	Continued From page 39 (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 residents). The findings include: On March 22, 2023, from approximately 10:40 a.m. to 2:45 p.m., survey staff toured the facility with Owner (O)-L and Maintenance (M)-O. During the facility tour, survey staff observed the following maintenance issues:	0 800			

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0 800	Continued From page 40 Upper Dakota: All sleeping rooms in Pods I, H, G and F had the egress windows secured shut from the inside by screws. Sleeping room 615 had a wood bar in the track and sleeping room 613A crank handle for the casement style window was missing. The building did not have a sprinkler system and all sleeping rooms are required to have a second means of egress. The door trim on the bathroom door in H-Pod was not secured in place. The edging was missing on the bathroom vanity in the G and F pod leaving the rough substrate exposed to residents. Lower Dakota: West Wing There was a hole in the ceiling of the nurse supply room and the bathroom adjacent to the nurse supply room. Damage appeared to be caused by a water leak from the level above. Broken furniture was being stored in the hallway which was part of the path of egress from the west wing. All surfaces through-out the west wing, except the occupied offices, were covered in a layer of dust and debris. Cobwebs and spiderwebs were hanging from the ceilings and windows. North Wing The ceiling was damaged in multiple locations in the bathroom of the north wing. The wallpaper trim was peeling off the walls and there was dark,	0 800			

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0 800	Continued From page 41 black, and brown staining on the ceiling and walls. Damage appeared to be caused by a water leak from the level above. The bathroom smell strongly of wastewater due to the shower drain trap being dry. The kitchen and dining room floor were covered in dead, dry salamanders, and other insects. All surfaces through-out the north wing were covered in a layer of dust. Cobwebs and spiderwebs were hanging from the ceilings, windows, and had gathered on the main entrance door. The exit door was obstructed by a build-up of snow and the only exit from the north wing was through the mechanical room and then through the west wing. The north wing was not currently occupied. East Wing The ceiling was damaged in multiple locations in the bathroom of the east wing. There was dark, black and brown staining on the ceiling and walls. Damage appeared to be caused by a water leak from the level above. All surfaces through-out the east wing were covered in a layer of dust. Cobwebs and spiderwebs were hanging from the ceilings, windows, and had gathered on the main entrance door. The exit door was obstructed by a build-up of snow and the only exit from the east wing was through the mechanical room and then through the west wing. The east wing was not currently occupied.	0 800			

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0 800	Continued From page 42 Shiloh Building #1 Both Laundry room exhaust fans we not working. On March 22, 2023, at approximately 2:45 p.m., O-L and M-O verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of 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	0 810		

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NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472			
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0 810	Continued From page 43 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide the required documentation of employee and resident training on fire safety and evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 22, 2023, at approximately 4:45 p.m. with Owner (O)-L and Executive Director/Registered Nurse (ED/RN)-B on the fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation	0 810			

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0 810	Continued From page 44 indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, O-L and ED/RN-B stated that the licensee policy is to train employees on fire safety and evacuation annually after initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. A policy on resident training for fire safety and evacuation was requested, but one was not able to be provided. O-L and ED/RN-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the	01420			

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01420	Continued From page 45 registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for the delegated tasks provided by the unlicensed personnel (ULP) for one of three residents (R1) whose delegated tasks included personal cares, brace application, and sit to stand lift transfers. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received transfer assistance three times per day. R1's service plan did not include assistance with braces. PERSONAL CARES R1's assessment dated January 11, 2023,	01420			

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01420	Continued From page 46 indicated R1 was dependent on the assist of two staff multiple times in a 24-hour period with toileting. On March 21, 2023, at 6:39 a.m., unlicensed personnel (ULP)-G stated R1 wanted to get up during the night. ULP-G stated, R1 was not able to get up during the night. ULP-G added, she could not get R1 out of bed, "I am by myself. I help her the best I can." On March 21, 2023, at approximately 6:45 a.m., ULP-G stated R1 didn't understand she cannot get R1 up. ULP-G added R1 complains she is wet when she is dry. ULP-G stated she put a blanket under R1 to lay on, "to try that." On March 21, 2023, at approximately 7:30 a.m., the evaluator observed R1 laying in a hospital bed wearing a night gown laying on a blanket. R1 did not have a brief on. On March 23, 2023, at approximately 8:50 a.m., clinical nurse supervisor (CNS)-C stated R1's assessment indicated R1 wore a brief, however, CNS-C stated sometimes R1 liked to sleep without a brief. CNS-C added the facility was in the process of getting more chuck pads for R1. BRACE On March 21, 2023, at approximately 7:50 a.m., the evaluator observed R1 sitting in a wheelchair R1 wearing a black hand/wrist brace on her left hand. ULP-F put socks on R1 and applied a leg brace to R1's left leg prior to dressing R1 with shoes. On March 23, 2023, at 8:48 a.m., CNS-C stated R1's record did not include any instructions for R1's left hand or left foot brace.	01420			

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01420	Continued From page 47 SIT TO STAND LIFT R1's assessment dated January 11, 2023, indicated R1 required assist of two staff with transfers and a transfer belt. May use sit to stand lift with assist of two if resident feels weak. In addition, R1 required assist with lower extremity brace. On March 21, 2023, at 7:40 a.m., the evaluator observed ULP-F bring a Best Care sit to stand lift (mechanical lift) into R1's room. Registered nurse (RN)-J stated she would assist with the transfer. RN-J added, she was going to watch ULP-F, "I don't do it [transfer] like this." ULP-F asked R1 to hold onto the bedrail with her right hand. ULP-F told R1 she had her arm "over her"[left arm]. ULP-F placed the sling of the sit to stand lift around R1. ULP-F placed R1's left arm over the side of the sling. R1's body was leaning back on the bed. ULP-F stated, "once we start standing, she puts her feet where they need to be. On March 23, 2023, at 8:52 a.m., CNS-C stated R1's assessment was not current, adding R1's record did not include directions for staff on how to use the sit to stand lift for R1. On March 23, 2023, at 8:54 a.m., agent (A)- N stated instructions for staff should be in R1's record so person centered care can be provided. The licensee's Delegated Nursing Services policy dated August 1, 2021, indicated a RN may delegate nursing services to ULP after: -completing a nursing assessment of the resident's functional status and need for nursing services; -developing a service plan for providing the services according to the resident's needs and	01420			

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01420	Continued From page 48 preferences; -determining that the ULP is trained and competent and has been instructed in the proper methods to perform the procedures with respect to the specific resident; and -including written instructions for performing the procedure for the resident in the resident's record. The licensee's Brace Splint Application policy dated August 1, 2021, indicated ULPs were to follow procedure instructions provided with brace/splint. See attached instructions/guidelines for use: document the procedure and report to nurse any concerns. Manufacturer's instructions for Best Care S dated 2019, indicated lift use to be -position lift towards the patient (resident) and open base; -open the base of the lift, position resident's feet on the footplate and knees against the knee pad; -attached the sling straps to the hooks; -have the resident's hands holding the handles. For residents who cannot hold the handles, have them hold their arms around the chest; -press the "up" button on the hand control; -before the resident's body has lifted from the bed, stop and make sure the sling is secured and resident's knees are against the knee pad; -the resident should be comfortable with the pressure under the arms. If not, adjust the sling and try another loop option to release pressure; -press the "up" button until the resident's body has completely left the bed; -transfer to another object can be done at this position with the resident attending a full standing position; -close the base, and pull the lift away from the bed;	01420			

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01420	Continued From page 49 -lower the resident to the object intend. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

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01470	Continued From page 50 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three employees, unlicensed personnel (ULP)-H's employee record contained orientation to assisted living facility licensing to include all the required topics. 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	01470		

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01470	Continued From page 51 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-H started employment March 16, 2023, to provide direct care services to the licensee's residents. On March 21, 2023, at 9:40 a.m., the evaluator observed ULP-H escort R11 to the dining room table for breakfast. ULP-H's employee record lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 23, 2023, at 9:05 a.m., registered nurse (RN)-B stated she was aware ULP-H's EduCare transcripts (computer training program) provided to the evaluator were from ULP's previous employment with another company. RN-B stated she just found out yesterday (March 22, 2023), orientation to assisted living facility requirements and guidelines training was not transferable and ULP-H should have received the	01470			

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01470	Continued From page 52 required training by the licensee prior to working on the floor with residents. The licensee's Orientation and Training policy dated August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01620 SS=E	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	01620			

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01620	Continued From page 53 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 for one of three residents (R1) and for a change of condition/hospital return for one of two 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 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: 14 DAY ASSESSMENT R1 R1 began receiving assisted living services on December 20, 2022. R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body), history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily, dressing assist, blood glucose checks four times daily, blood	01620		

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01620	Continued From page 54 pressure monitoring daily, special dressing three times daily, oxygen saturations two times daily, pulse monitoring twice daily, temperature twice daily, toileting reminder fourteen times daily, transfer assistance three times daily, assistance with bathing twice weekly, behavior management three times daily, and housekeeping services. On March 21, 2023, at approximately 7:50 a.m., the evaluator observed R1 sitting in a wheelchair, wearing a black hand/wrist brace on her left hand. Unlicensed personnel (ULP)-F put socks on R1 and applied a leg brace to R1's left leg prior to dressing R1 with shoes. R1's record included a "Clinical Update" assessment dated January 11, 2023. On March 22, 2023, at 11:40 a.m., RN-B confirmed a reassessment for R1 on day 14 was not completed as required. R1's 14-day assessment was completed on day 23, nine (9) days late. CHANGE OF CONDITION ASSESSMENT/HOSPITAL RETURN On March 20, 2023, at 10:59 a.m., during the entrance conference RN-B stated change of condition assessments were completed with hospital return, changes in status such as fall and Hospice. R4 R4 began receiving assisted living services on August 17, 2021. R4's diagnoses included chronic obstructive pulmonary disease (COPD/a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) and heart failure.	01620			

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01620	Continued From page 55 R4's service plan dated December 27, 2022, included activity assistance two times daily, bathing assist two days a week, behavior management three times daily, dressing two times daily, grooming daily, medication administration seven times daily, nebulizer maintenance three times daily, oxygen delivery three times daily, monitoring of vital signs, skin care two times daily, laundry and housekeeping service. On March 21, 2023, at approximately 8:15 a.m., the evaluator observed ULP-F administer R4's morning oral medication, nebulizer, and eye medication. R4's Resident Notes included the following: -January 25, 2023, at 11:35 a.m., CNS-C noted RN received telephone call from LALD (licensed assisted living director) at 0430 (4:30 a.m.). LALD reported that resident wanted to go to the ER as "I feel like I am filling up with fluid." RN instructed LALD to call EMS (emergency medical services) -January 25, 2023, at 7:26 p.m., an unidentified RN noted she had spoken with a RN at [hospital]. R4 had been admitted to the hospital for a CHF (congestive heart failure) exasperation requiring IV (intravenous) medication. The hospital RN stated R4 would probably be admitted for the next day or two. -January 26, 2023, at 1:32 p.m., unidentified RN noted received a telephone call from discharge planner at hospital. R4's discharge was approved and R4 was scheduled for a 4:45 p.m., transport back to the assisted living. -January 26, 2023, unidentified RN noted at 5:39 p.m., R4 returned from hospital at approximately 1740. R4 denied any shortness of breath or any pain. Vital signs were 138/58, 64, 18, 96 % on 2	01620		

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NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472			
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01620	Continued From page 56 liters nasal cannula (oxygen) R4 up ambulating independently, no shortness of breath or cough noted. Upper lobes of lungs are diminished but clear expiratory wheezes bilaterally in lower lobes of lungs. Note entered on January 27, 2023, at 3:05 p.m. R4's "recent Hospital admit" assessment was dated January 28, 2023. R4 returned to the facility on January 26, 2023, two days prior the assessment. On March 23, 2023, at approximately 2:40 p.m., clinical nurse supervisor (CNS)-C stated R4's hospital return assessment dated January 28, 2023, was not completed on January 26, 2023, as required. CNS-C added she would not have completed the assessment on a Saturday. The licensee's Assessment, Monitoring, & Reassessment- Schedule (s) policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monition 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. In addition, the community would conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the community. Assisted Living Facilities: Minnesota Rules Chapter 4659, rule 4659.1040, Subp. 7. Weekend Assessments. An assisted living facility must be able to conduct a nursing assessment on a holiday or on a weekend for a resident who is read to be discharged from the hospital and	01620			

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01620	Continued From page 57 return to the facility. 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 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 one of three residents (R1) service plans were revised to include provided services. In addition, the	01640			

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01640	Continued From page 58 licensee failed to ensure one of three residents (R4) service plans provided all services required by the current service plan. 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: SERVICE PLAN REVISION R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily, dressing assist, special dressing three times daily (face mask encouragement), transfer assistance three times daily, and behavior management three times daily. R1's assessment dated January 11, 2023, included: -full help to dress and undress (zippers, assist of one with dressing, buttons, trying shoelaces, etc); -needed help with lower extremity brace; -did not require escorts; and -requires full help with wheelchair for mobility. March 21, 2023, at approximately 7:50 a.m., the	01640			

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01640	Continued From page 59 evaluator observed R1 sitting in a wheelchair wearing a black hand/wrist brace on her left hand. Unlicensed personnel (ULP)-F put socks on R1 and applied a leg brace to R1's left leg prior to dressing R1 with shoes. On March 21, 2023, at approximately 9:05 a.m., the evaluator observed registered nurse (RN)-B push R1's wheelchair from the dining room to R1's room. On March 23, 2023, at 8:38 a.m., clinical nurse supervisor (CNS)-C confirmed R1's service plan was not revised as required. CNS-C stated she did not do R1's admission. CNS-C acknowledged R1's left leg brace, left hand splint, and mobility were not addressed on R1's service plan. CNS-C stated they want to encourage R1 to self-propel wheelchair but they provide assistant as needed. CNS-C added R1's hand splint and R1's left leg brace were "on my list". SERVICE PLAN IMPLEMENTATION R4's diagnoses included chronic obstructive pulmonary disease (COPD/a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) and heart failure. R4's service plan dated December 27, 2022, included dressing AM (morning), dressing PM (evening) daily. On March 21, 2023, at approximately 8:15 a.m., the evaluator observed ULP-F administer R4's morning oral medication, nebulizer and eye medication. The evaluator observed R4 wearing a button up blue plaid shirt that was soiled. On March 22, 2023, at approximately 1:35 p.m., the evaluator observed R4 in the same button up	01640			

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01640	Continued From page 60 blue plaid soiled shirt worn on March 21, 2023. R4 stated he gets no assistance with dressing; he does his own. R4's RTask documentation (online documentation system) dated March 20, 2023, to March 23, 2023, included instructions to assist resident with dressing by cueing, setting out clothes or providing assistance with dressing. Service was marked as completed March 20, 2023, through March 23, 2023. R4's Service Recap Summary dated March 1, 2023, through March 21, 2023, indicated dressing assist was provided 21 of 21 times in the AM, and 19 of 20 times dressing assist was provided. R4 refused one (1) time. On March 23, 2023, at approximately 2:35 p.m., CNS-C stated R4 refusing dressing assist. CNS-C added she was "not sure" why staff are "charting" dressing was completed for R4. CNS-C stated when she helps, she documented service as refused. CNS-C added ULPs were trained to document service as refused. The licensee's Service Plan-Modification policy dated August 1, 2021, indicated the service plan or agreement must be modified due to a change in a prescriber's order or a change in the resident's needs, or change in condition, or change in fee: -a list of changes in service; -changes in service frequency; -who is to perform the service; -frequency of supervision; -charge (s) for the service; -date/signature of RN making changes; -date/ signature of resident or the resident's representative each time a modification is made	01640			

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01640	Continued From page 61 (the signature may be obtained by mail or fax if an agreement was reached in person or by telephone). The licensee's Assisted Living Documentation policy dated August 1, 2021, indicated all documentation regarding care and services given to each resident becomes part of the legal medication record. There is no way to prove care was provided without complete documentation. If a resident suffers an illness or injury and care was not completely and accurately documented (ex. pressure sores from lack of documentation of turning and reporting), then it is doubtful quality care was completed, even though nursing staff may insist that such care was provided. The resident's medical record is the main mechanism by which state surveyors, attorneys, and the attorney's experts will evaluate the quality of care provided by the nursing home and its staff if episodes of suspected neglect or mistreatment occur. The importance of complete & accurate documentation cannot be overemphasized. Consequences of poor documentation: resident's receive poor quality care that may lead to injuries, and even death; -nurses and HHA (ULPs) do not receive information they need to provide high quality nursing care; -nursing supervisors do not have information needed to determine if care has been effective; and -the assisted living can be fined for lack of documentation by the State and may even suffer legal ramifications from lawsuits. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			

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01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the 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 prescribed for three of four residents (R8, R10, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: INHALHED MEDICATION R8	01760			

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01760	Continued From page 63 R8's diagnoses included chronic obstructive pulmonary disease (COPD) and depression. R8's service plan dated June 28, 2022, indicated R8 received medication administration services. R8's unsigned and undated prescriber orders included the following medications: -albuterol 90 micrograms (mcg) two (2) puffs by mouth daily for shortness of breath and mometasone furoate 100 mcg inhale two (2) puffs by mouth twice a day for COPD. Instructions for each inhaler included to wait at least one (1) minute in between puffs of same medications, wait at least five (5) minutes before administering different inhaled medications and rinse mouth out after inhaled medications; and -sertraline 50 milligram (mg) (used to treat depression) take one-half tablet daily with food. R8's March's Medication Administration Record indicated R8 was to receive the following medications: -albuterol inhaler two puffs daily and mometasone furoate two (2) puffs twice a day, wait at least one (1) minute in between puffs of the same medication, wait at least five (5) minutes before administering different inhaled medications and provide the opportunity to rinse mouth out; and -sertraline take one-half tablet (50 mg) daily with food. On March 21, 2023, at 8:00 a.m., the evaluator observed ULP-I administer R8's morning medications to include sertraline 100 milligrams (mg) ½ tablet to be given with food. ULP-I handed R8 his albuterol inhaler. R8 inhaled two (2) puffs from inhaler, not waiting one minute in between puffs as directed then ULP-I immediately handed R8 his mometasone inhaler and R8	01760			

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01760	Continued From page 64 inhaled two (2) puffs of the inhaler again not waiting one minute in between puffs. ULP-I did not remind R8 to rinse his mouth after the use of the inhalers and R8 laid back in bed and ULP-I gathered R8's inhalers and exited R8's room. On March 21, 2023, at 8:45 a.m., R8 was observed sitting at the breakfast table eating breakfast. On March 21, 2023, at 9:49 a.m., ULP-I reviewed R8's MAR's written instructions for inhalers and sertraline. ULP-I stated she did not instruct R8 to wait one minute in between puffs or waited five minutes in between the use of albuterol and Asmanex inhalers or instructed R8 to rinse his mouth after the inhaler as directed. Further, ULP-I stated R8's sertraline was not given with food as directed and confirmed R8 did not go down for breakfast after taking his medications and laid back in bed. On March 23, 2023, at 2:47 p.m., registered nurse (RN)-J stated she would expect staff to follow the directions on the resident's medication administration record when administering medications for specific instruction. RN-J confirmed R8's MAR instructed staff to wait one (1) minute in between puffs of the inhaler and wait five (5) minutes in between inhalers and rinse mouth after the use of inhaler. RN-J stated if directions indicated a medication was to be given with food, RN-J stated she would expect staff to administer the medication at the dining table or make sure the resident was going to eat within 15 minutes after administering the medication. The licensee's Inhaler policy dated August 1, 2021, indicated inhaler medications must be	01760			

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01760	Continued From page 65 administered according to the prescriber's orders and verified with the manufactures requirements per instructions. When administering inhaler medications wait at least one (1) minute in between puffs of the same medications, wait at least five (5) minutes before administering different inhaled medications and provide the resident the opportunity to rinse out mouth. INJECTABLE MEDICATION R10 R10's diagnosis include heart failure and diabetes. R10's service plan dated January 1, 2023, indicated R10's services included blood glucose monitoring four (4) times daily. R10's prescriber's ordered dated December 8, 2022, included Novolog FlexPen (fast acting insulin) 3 units subcutaneous at 8:00 a.m. -wash hands and apply gloves, pull pen cap straight off. -check the liquid in the pen, should be clear and colorless; -wipe top of pen with alcohol swab; -always use a new needle for each injection; -push the capped needle straight onto the pen and twist the needle on until tight; -pull off outer cap; -priming your pen; hold the pen with needle point up, turn the dose selector to select 2 units: -hold the pen with the needle point up; -press and hold dose button until dose counter show "0"; -0 must line up with the dose pointed; -a drop of liquid should be seen at the needle tip. If you do not see a drop repeat above steps. If you do not se a drop after 3 tries, change the needle and try again;	01760		

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01760	Continued From page 66 -turn dose selector to select the number of units you need injected; -the dose pointer should line up with your dose. If you select the wrong dose you can turn the dose forward or backward to the correct does; -even numbers are printed on the dial, the odd numbers are shown as lines; -a second HHA (ULP) or licensed nurse will check the 6 rights; -if correct second staff will initial in the co-check space on the MAR (medication administration record). On March 21, 2023, at 8:44 a.m., the evaluator observed unlicensed personnel (ULP)-F removed R10's Novolog FlexPen from a medication cart. ULP-F placed a disposable needle on the insulin pen and dialed the pen to 2 units to prime the insulin pen. ULP-F got a second staff to check the insulin amount. ULP-F using correct technique administered R10's insulin in her lower right abdomen. On March 21, 2023, directly following the above observation ULP-F stated the pen should have been cleaned before the needle was applied with alcohol. ULP-F added she was trained that way, to clean the insulin pen before and after needle application. On March 23, 2023, at 11:15 a.m., clinical nurse supervisor (CNS)-C stated ULPs should clean insulin pen's prior to applying the needle. CNS-C added that is how ULPs are trained. The licensee's Insulin Pen policy dated August 1, 201, indicated insulin pen(s) could be used by trained HHA (ULP) and residents competent to self-administer an insulin pen; -wash hands;	01760			

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01760	Continued From page 67 -gather supplies; -check label on pen to be sure it contains the type of insulin that was prescribed by physician; -pull pen cap start off; -check the liquid in the pen, should be clear and colorless unless insulin in suspension (cloud); -if your insulin is suspension (cloudy); roll the pen back and forth between your hands 10 times; - gently turn the pen up and down 10 times unit insulin is evenly mixed; -wipe top of pen with alcohol swab; -always use a new needle for each injection; -push the capped needle straight onto the pen and twist the needle on until tight; and -pull off out cap. ORAL MEDICATION R1 R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily. R1's prescriber's orders dated March 21, 2023, included the following medications: -aspirin chew 81 mg tablet, by mouth, one (1) time a day. "Chew 1 tablet by mouth once daily;" -glipizide (diabetes) five (5) mg tablet by mouth. "1 tablet by mouth daily before AM (morning) meal;" On March 21, 2023, at 8:45 a.m., the evaluator observed R1 sitting at a dining room table eating eggs, bacon, and toast.	01760		

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01760	Continued From page 68 On March 21, 2023, at approximately 9:05 a.m., the evaluator observed ULP-F remove aspirin 81 mg and glipizide 5 mg from a medication cart and put the medications into a medication cup. On March 21, 2023, at approximately 9:15 a.m., the evaluator observed ULP-F give the medication cup to R1 and R1 swallowed the medications. On March 21, 2023, at 9:20 a.m., registered nurse (RN)-B stated R1's glipizide 5 mg should have been given prior to a meal. RN-B asked clinical nurse supervisor (CNS)-C about R1's glipizide 5 mg and CNS-C stated the medication was scheduled at 8:00 a.m., On March 23, 2023, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-C stated R1's Glipizide 5 mg given after the meal was a medication error. In addition, CNS-C stated the pharmacy puts "chew" on R1's aspirin 81 mg, adding it would technically be a medication error adding she would look into this. The licensee's medication & Treatment Management Plan (s) policy dated August 1, 2021, indicated the RN would delegate medication administration and treatment services to the trained HHA(s) (ULP). The RN must instruct the ULP on the following medication administration tasks before delegating the task to them: -the complete procedure of checking a resident' medication administration record; -the preparation of medication for administration; -the administration of the medication to the resident; -the reminder to self-administer medication; and -the documentation after assistance with	01760			

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01760	Continued From page 69 medication reminder or medication administration, of the date, time, dosage, and method of administration of all medication, the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to renew prescriptions at least every 12 months for one of three residents (R8). 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:	01830			

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01830	Continued From page 70 During entrance conference on March 20, 2023, at 10:48 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services for residents. R8's diagnoses included chronic obstructive pulmonary disease (COPD) and depression. R8's service plan dated June 28, 2022, indicated R8 received medication administration services. R8's unsigned and undated prescriber orders included the following medications: -albuterol inhaler 90 micrograms (mcg) two puffs daily for shortness of breath; -artificial tears one (1) drop in both eyes twice a day for dry eyes; -aspirin 81 milligrams (mg) one tablet by mouth daily for heart health; -lisinopril 2.5 mg one tablet by mouth daily for high blood pressure; -metformin 1000 mg one tablet by mouth twice a day for diabetes; -mometason furoate inhaler 100 mcg two (2) puffs twice a day for COPD; -oxygen two (2) liters with exertion and four (4) liters per minute via nasal cannula daily for COPD; -pioglitazone 15 mg ½ tablet by mouth daily for diabetes; -risperidone 3 mg one tablet by mouth at bedtime for thought disorder; -sertraline 100 mg ½ tablet by mouth daily with food for depression; and -simvastatin 80 mg ½ tablet by mouth daily for elevated cholesterol. R8's March Medication Administration Record (MAR) listed medications as prescribed as noted	01830			

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01830	Continued From page 71 above, times to administer, and staff initials to indicate the medications had been given. On March 21, 2023, at 8:00 a.m., unlicensed personnel (ULP)-I was observed administering R8's scheduled morning oral medications and inhalers. On March 22, 2023, 12:52 p.m., clinical nurse supervisor (CNS)-C stated annual medication orders were faxed to R8's provider a few months ago and realized they never received signed annual orders. The licensee's Medication and Treatment Orders-Renewal dated August 1, 2021, indicated medication and treatment orders would be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications were new or changed and the signed orders would be placed in the resident's permanent record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
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	01880			

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01880	Continued From page 72 review, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures. In addition, the licensee failed to ensure medication was secured in a locked area for 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: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On March 20, 2023, at 1:45 p.m., the evaluator toured the medication room on Shiloh unit with registered nurse (RN)-B including a review of the medication refrigerator. RN-B provided the evaluator with Shiloh's recorded temperature logs from January 1, 2023, through February 7, 2023. RN-B confirmed January and February 2023, paper logs were missing several entries and RN-B stated there were no temperatures recorded for the month of March 2023, unless they were documented in the electronic record. RN-B stated the night shift was responsible for recording the temperature logs and would expect staff to complete the task daily as directed. RN-B stated the current refrigerator temperature was 32 degrees Fahrenheit (F) and should be between 36-46 degrees F. RN-B did not make any adjustments to the refrigerator temperature at that time. RN-B observed the medication	01880			

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01880	Continued From page 73 refrigerator and confirmed the following contents: -23 unopened Novolog (short acting) insulin pens; -seven (7) unopened Basaglar (long-acting) insulin pens; -11 unopened Lantus (long-acting) insulin pens; -13 unopened Humalog (fast-acting) insulin pens; -one (1) unopened Ozempic injectable pen (a noninsulin injection to treat diabetes); -five (5) Lorazepam (used to treat anxiety) 2 milligrams/milliliters (mg/ml) vials; -two (2) opened gabapentin (used to treat seizures) 250 mg/5 ml solution bottles; and -two (2) unopened bottles of Latanoprost eye drops (used to treat increased eye pressure). Shiloh's electronic temperature logs dated January 1, 2023, to March 21, 2023, indicated the following: -seven (7) out of 49 opportunities the recorded temperatures were out of range and documented below 36 degrees F; and -28 out of 49 opportunities the temperature was recorded as being "done, completed, or ok" and lacked a recorded temperature. The manufacturer's instructions for Basaglar insulin dated 2022, indicated to store unopened Basaglar insulin in the refrigerator between 36-46 degrees F. Do not allow Basaglar to freeze. The manufacturer's instructions for Lantus Solostar insulin dated June 2022, indicated to store unopened Lantus in a refrigerator between 36-46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Humalog Kwikpen insulin dated November 2019, indicated to store unopened Humalog in a refrigerator between 36-46 degrees F. Do not allow Humalog to freeze.	01880		

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01880	Continued From page 74 The manufacturer's instructions for Ozempic injection pen revised 2022, indicated to store in the refrigerator between 36-46 degrees F. Do not allow Ozempic to freeze. The manufacturer's instructions for Lorazepam oral concentrate revised August 2022, directed to store at cool temperatures between 36 to 46 degrees F. The manufacturer's instructions for gabapentin (Neurontin) oral solution revised October 2017, indicated to store in the refrigerator between 36-46 degrees F. Do not allow gabapentin to freeze. The manufacturer's instructions for latanoprost dated August 2011 indicated to store unopened bottles in the refrigerator between 36-46 degrees F. Do not freeze. SECURE MEDICATION STORAGE On March 21, 2023, at approximately 8:10 a.m., the evaluator observed unlicensed personnel (ULP)-F prepare R2's oral morning medication at the medication cart. ULP-F stated R4's brimonidine (glaucoma/high pressure in the eye) was in R4's room. ULP-F took a medication cup and a vial of nebulizer solution to R4's room. R4 was sitting at a table and on the table was a bottle of brimonidine 0.2% eye solution, latanoprost (glaucoma) 0.005% eye solution, Muro (dry eye) 128 5% eye drops eye solution, and fluticasone (sneezing, runny, stuffy nose) 50 micrograms nasal spray. R4's Individualized Medication Management Plan dated January 28, 2023, indicated resident was unable to take medications independently related	01880			

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01880	Continued From page 75 to mental health diagnoses. Staff to complete medications under the delegation and supervision of the RN and all medications were locked in medication cart. In addition, resident was able to self-administer his OTC (over the counter) creams, patches and cough drops. R4 had been educated on the correct way to use each of these medications. R4 had a lock box in his room that his OTC creams, patches and cough drops must be stored in. On March 23, 2023, at 2:32 p.m., clinical nurse supervisor (CNS)-C stated R4 does have some medication he can keep in his room however brimonidine, latanoprost, Muro and fluticasone should be kept in the locked medication cart. The licensee's Storage of Medication policy dated August 1, 2021, indicated medications would be stored consistent with each individual residents' medication management plan and service plan. When medications are managed and stored by the licensee, medications would be stored consistent with the manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890			

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01890	Continued From page 76 drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for six of seven residents (R4, R12, R13, R14, R15, R16). In addition, the licensee failed to ensure medications were maintained bearing the original prescription label for three of seven residents (R14, R15, R4). Further, the licensee failed to monitor for expired medications for one of seven residents (R13). 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: TIME SENSITIVE MEDICATIONS/ORIGINAL PRESCRIPTION LABEL On March 20, 2023, at 1:28 p.m., the evaluator observed Shiloh's West medication cart with registered nurse (RN)-J. RN-J confirmed the following: -R4's opened albuterol inhaler (used to treat shortness of breath and wheezing) lacked the date the inhaler had been opened and when the inhaler would expire. -R12's two opened bottles of lubricant eye drops lacked when eye drops were opened and when the eye drops would expire. -R13's opened Ventolin inhaler (used to treat	01890			

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01890	Continued From page 77 shortness of breath and wheezing) lacked the date the inhaler had been opened and when the inhaler would expire. On March 20, 2023, at 2:04 p.m., the evaluator observed Shiloh's East medication cart with RN-B. RN-B verified the following: -R14's opened latanoprost eye drop (used to treat high pressure in the eye) lacked the date the eye drop had been opened and when the eye drop would expire. In addition, R14's opened Alphagan eye drop lacked an original prescription label with the information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which the medication had been issued. -R15's opened albuterol inhaler lacked the date the inhaler had been opened and when the inhaler would expire. In addition, R15's albuterol inhaler lacked an original prescription label with information regarding the directions for use, medication name, medication, resident's name, and the pharmacy in which it had been issued. -R16's two (2) opened latanoprost eye drops lacked the date the eye drops were opened and when the eye drops would expire. On March 21, 2023, at 8:19 a.m., the evaluator observed unlicensed personnel (ULP)-F assisting R4 with his morning medication. ULP-F confirmed the following: -R4's open brimonidine 0.2% eye solution (glaucoma/high pressure in the eye) lacked the date the eye drop had been opened and when the eye drop would expire. R4's opened latanoprost (glaucoma) 0.005% eye solution) lacked the date the eye drop had been opened and when the eye drop would expire. R4's opened Muro eye solution did not have a label which indicated the date the eye drops had been opened and when	01890		

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01890	Continued From page 78 the eye drop would expire. In addition, R4's Muro (dry eye) eye solution lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issues. EXPIRED MEDICATIONS -R13's opened albuterol inhaler had expired January 31, 2023. On March 20, 2023, at 2:17 p.m., RN-B confirmed staff should be writing the date inhalers, eye drops, and insulins were opened on the prescription labels. On March 23, 2023, at 2:32 p.m., clinical nurse supervisor (CNS)-C stated medications should have dates when opened and medications are to be label with resident's names and required information. The manufacturer's instructions for albuterol inhaler revised September 2017, directed not to use after the expiration date on the packaging. The manufacturer's instructions for Ventolin inhaler dated April 2019, directed discard inhaler 12 months after removal from the foil pouch. The manufacturer's instructions for latanoprost eye drops dated April 28, 2022, directed eye drops could be used for up to six weeks when stored at room temperature, under 77 degrees. The manufacturer's instructions for Alphagan eye drop revised February 2022, directed to discard 28 days after opened. The manufacturer's instructions for brimonidine	01890			

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01890	Continued From page 79 eye drops dated December 7, 2021, directed eye drops could be used for 30 days after opening and should be discarded after that time even if some solution was remaining. The manufacturer's instructions for Muro 128 5% eye drops dated March 31, 2022, directed eye drops could be used for 30 days after opening. The licensee's Storage of Medication policy dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications would be stored consistent with the manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	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,	01910			

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01910	Continued From page 80 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R5) 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 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: R5 was discharged on January 31, 2023. R5's January 2023, Medication Administration Summary indicated R5 received the following medications: -acetaminophen (treats minor pain or fever) 325 mg 20 tablets; -finasteride (treats enlarged prostate) 5 mg daily; -levothyroxine (treats underactive thyroid) 25 micrograms one tablet daily; and -tamsulosin (treats enlarged prostate) 0.4 mg one capsule. R5's Discharge - Transfer Summary dated February 6, 2023, noted medications were	01910			

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01910	Continued From page 81 destroyed. In addition, the summary noted R5 received assistance with medication management including administration. The summary included a Medication Disposition Summary, which noted disposition of medications to include the medication name, quantity, and strength, however; lacked the prescription (Rx) numbers for the following disposed medications: -clotrimazole 10 milligrams (mg) two (2) tablets, which was not identified on R5's January 2023, MAR; -acetaminophen 325 mg 20 tablets; -finasteride 5 mg eight (8) tablets; -levothyroxine 25 micrograms (mcg) 38 tables; and -tamsulosin 0.4 mg 10 capsules. On March 22, 23, 2023, at 12:35 p.m., registered nurse (RN)-B confirmed R5's disposition of medications lacked all of the required prescription numbers of the medications that were destroyed. RN-B stated R5's medications destruction sheet was completed by a nurse who no longer was employed by the licensee. On March 22, 2023, at 1:17 a.m., clinical nurse supervisor (CNS)-C revived R5's Medication Disposition Summary and confirmed the following missing Rx number as indicated above and was unaware it was a requirement. The licensee's Disposition of Medication dated August 1, 2021, indicated upon disposition, the comprehensive assisted living provider must document in the resident medication destruction record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in	01910			

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01910	Continued From page 82 the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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: (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	01950			

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NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472			
(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
01950	Continued From page 83 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 (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: R10's diagnosis include heart failure and diabetes. On March 21, 2023, at 7:14 a.m., the evaluator observed unlicensed personnel (ULP)-F hold a FreeStyle blood glucose monitor up to R10's upper right arm to obtain R10's blood glucose level. R10's service plan dated January 1, 2023, indicated R10's services included blood glucose monitoring four (4) times daily. R10's assigned to AM (morning) task ULP form dated January 24, 2023 and scheduled daily included: resident now has a sensor on her arm. Please use the machine on her dresser to scan the sensor for blood sugar checks. If glucose is over 500 milligrams/deciliter (mg/dL), registered nurse (RN) to call provider for further instruction. On March 23, 2023, at approximately 10:00 a.m., clinical nurse supervisor (CNS)-C stated she	01950			

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01950	Continued From page 84 does not train the ULPs on FreeStyle blood glucose monitoring system. CNS-C added she has instructions printed in R10's record and she "thought" that was sufficient. The licensee's Medication & Treatment Management Plan(s) policy dated August 1, 2021, indicated medication and treatment management service provided by unlicensed personnel to home care (assisted living) resident would be performed consistent with Minnesota Comprehensive Home Care Rules, including prior training and competency testing supporting the resident's individualized medication management plan. Prior to a ULP providing delegated medication administration and treatment services, the following must occur: -a RN must conduct a face-to face resident assessment to determine what medication and treatment management services would be provided, and how those services would be provided; -the service plan would include medications and treatments administered per MD (medical doctor) order; -the chart would have current MD medications and treatment orders; -EMAR (electronic medication record) would include medication, DX (diagnosis), side effects and specific instructions for resident; -EMAR or treatment record would contain specific instructions for resident; -the RN would delegate medication administration and treatment services to the trained HHA(s) (home health aide/ULP); -the ULP must demonstrate their ability to competently follow the delegated medication administration and treatment services to a RN; - and -written records, signed by a RN, shall be	01950		

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01950	Continued From page 85 maintained regarding ULP training and competency testing of delegated medication administration and treatment services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of two residents (R3) with oxygen administration. In addition, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of three residents (R1) with health monitoring managed by the provider. This practice resulted in a level two violation (a	01960		

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01960	Continued From page 86 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: R3 R3's diagnoses included shortness of breath and iron deficiency anemia. R3's Service Plan dated July 12, 2022, included oxygen delivery three (3) times per day, daily. R3's provider's orders dated December 8, 2022, included oxygen 2 liters per minute (LPM), apply oxygen per nasal cannula at 2 LPM continuously. On March 20, 2023, at 3:37 p.m., the evaluator observed unlicensed personnel (ULP)-D administer R3's afternoon medication. R3 was lying in bed. In R3's room there were twelve oxygen tanks in a rack and one oxygen tank in a holder, there was also an oxygen concentrator running with a nasal cannula on top of the concentrator. The evaluator observed ULP-D place the nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) on R3. On March 20, 2023, directly following the above observation ULP-D stated R3 was to have the oxygen on at all times. ULP-D added staff move her in bed and forget to put the nasal cannula back on R3.	01960			

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01960	Continued From page 87 On March 20, 2023, at 3:52 p.m., registered nurse (RN)-B confirmed R3's oxygen was to be administered at all times adding the nasal cannula should "move" with resident at all times. On March 23, 2023, at 4:00 p.m., clinical nurse supervisor (CNS)-C stated R3's oxygen is ordered to be worn continuously and should be on continuously. CNS-C added she had to remind staff to apply oxygen cannula. The licensee's Oxygen Concentrator Use policy dated August 1, 2021, indicated to meet needs of oxygen dependent resident, oxygen would be provided per concentrator per doctor order. For residents requiring low flow therapeutic oxygen, this is a convenient and economical alternative to cylinder or liquid oxygen: -resident's physician shall submit orders for oxygen; -explain oxygen therapy and any limitation or restrictions to the resident; -attach any appropriate oxygen tubing; -plug unit into electrical outlet. Turn power switch on. Keep unit 8-10 inches from wall or furniture to allow air flow; and -use cannula. Adjust comfortably in nostrils. R1 R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body), history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily, dressing assist, blood glucose checks four times daily, blood pressure (BP) monitoring daily, oxygen	01960			

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01960	Continued From page 88 saturations twice daily, pulse monitoring twice daily, temperature twice daily, and behavior management three times daily. R1's provider's ordered dated March 21, 2023, included daily blood pressure monitoring. R1's Vital Signs record dated February 22, 2023, through March 22, 2023, indicated BP readings had been recorded 29 out of 29 opportunities; 20 out of the 29 times R1's BP (systolic, top number, measures the force the heart exerts and diastolic, bottom number, measures the force the heart exerts between beats/at rest) were recorded as being in the acceptable range. Nine days R1's BP reading (diastolic) were 56, 57, 47, 57, 53, 57, 58, 56, 59. On March 23, 2023, at 9:11 a.m., clinical nurse supervisor (CNS)-C confirmed staff should follow instructions when providing monitoring services, nursing should have been notified of low blood pressure readings, "they were a little low a few times". There was a posting on each medication cart that included to notify nursing of blood pressure reading less than 90/60 or greater than 140/90. CNS-C stated ULPs are trained to report out of range findings. The licensee's Vital Signs policy dated August 1, 2021, indicated staff were to contact nurse if vital signs were out of normal range. Blood pressure: 90/60 millimeters of mercury (mm/hg) to 120/80 mm/hg. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

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01970	Continued From page 89	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to renew treatment orders at least every 12 months for one of one resident (R8). 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: During entrance conference on March 20, 2023, at 10:48 a.m., registered nurse (RN)-B confirmed the licensee provided treatment services for residents to include oxygen management. R8's diagnoses included chronic obstructive pulmonary disease (COPD).	01970			

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01970	Continued From page 90 R8's service plan dated June 28, 2022, indicated R8 received oxygen management services. R8's unsigned and undated prescriber orders included the following treatments: -oxygen two (2) liters with exertion and four (4) liters per minute via nasal cannula daily for COPD. R8's March Medication Administration Record (MAR) indicated the following treatments were administered: - oxygen daily two (2) liters with exertion and four (4) liters per minute via nasal cannula daily for COPD. On March 21, 2023, at 8:00 a.m., during R8's scheduled morning administration of medications and inhalers, R8 was observed wearing his oxygen via nasal cannula. On March 22, 2023, 12:52 p.m., clinical nurse supervisor (CNS)-C stated annual orders were faxed to R8's provider a few months ago and realized they never received R8's signed annual treatment orders. The licensee's Medication and Treatment Orders-Renewal dated August 1, 2021, indicated medication and treatment orders would be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications were new or changed and the signed orders would be placed in the resident's permanent record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			

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02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: A review of the Hazard Vulnerability Assessment showed global hazards such as fire, gas leaks, and epidemics but did not include hazards or safety risks identified on and around the property.	02040			

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02040	Continued From page 92 During an interview on March 22, 2023, at 4:45 p.m., the Owner (O)-L and Executive Director/Registered Nurse (ED/RN)-B confirmed during an interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in one of one secured unit (Dakota). This had the potential to affect all 18 residents residing in the secured unit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	02070			

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02070	Continued From page 93 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order identified on March 21, 2023. The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 70 residents and had a current census of 38 residents. The physical layout of the campus consisted of an assisted living building [Shiloh one (1) and Shiloh two (2)] which were connected and approximately 1,056 feet away was the secured unit [Dakota House], which was not physically connected to the assisted living building. On March 20, at 10:51 a.m., during the entrance conference registered nurse RN-B confirmed the facility's staffing schedule included one unlicensed personnel (ULP) scheduled on the overnight shift (11:00 p.m. to 7:30 a.m.), in the Dakota House [a secured unit requiring a key code to exit] and one ULP in the Shiloh House [assisted living]. RN-B and RN-J confirmed there was one resident in the secured unit and three (3) residents in the assisted living which required a mechanical lift and two staff to assist with resident transfers. RN-B stated staff on the night shift would have to leave their unit unattended to assist with any two-person resident transfers. On March 21, 2023, at 6:35 a.m., the evaluator	02070			

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02070	Continued From page 94 entered the secured unit and observed one staff working. ULP-K stated there were two (2) staff scheduled to work the night shift, one staff in the secured unit and one staff on assisted living. ULP-K confirmed there was one resident in the secured unit and three (3) resident which required two staff to assist with transfers. ULP-K further stated staff would have to leave the secured unit unattended and drive to the assisted living to assist with resident transfers about two (2) times at night. ULP-K stated the secured unit was left unattended for about 10 minutes each time. On March 21, 2023, at 12:53 p.m., RN-B stated she was aware the secured unit should never be left unattended. Further, RN-B stated when staff left the secured unit unattended it was on a rare occasion to assist the assisted living staff with resident transfers and staff were only gone a short period of time. The evaluator asked how the licensee was to assure there was adequate staffing for when Shiloh two (2) opened. RN-B stated the assisted living was a business and the rooms needed to be filled. RN-B stated the night shift was the only shift that was short staffed, and the licensee has been trying to find staff to fill the float position on the night shift. On March 21, 2023, at approximately 1:20 p.m., owner (O)-L stated the assisted living was on a 20-acre property and was unable to provide the evaluators the distance between the assisted living and the secured unit. The licensee's Staffing Plan policy dated August 29, 2019, indicated the purpose of this policy was to provide guidance on staffing in assisted living communities operated by [name of company]. The plan must be reviewed by the CNS bi-annually or as resident acuity requires. This	02070			

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02070	Continued From page 95 policy included: -community name, Shiloh [assisted living]- Dakota [secured unit] will operate with 4 (day) staff; -community name, Shiloh- Dakota will operate with 4 (evening) staff; and -community name, Shiloh-Dakota will operate with 2 NOC (night) day. The Uniform Assessment Tool dated May 20, 2023, indicated the licensee typically scheduled the number of ULPs for each for the following shifts: Day Shift (7:00 a.m., to 3:30 p.m.) four (4) ULPs; Evening shift (3:00 a.m., to 11:30 a.m.) four (4) ULPs; and Night shift (11:00 p.m., to 7:30 a.m.,) two (2) ULPs. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyors' on-site observation and review by evaluation supervisor on March 22, 2023, however, non-compliance remains at a scope and level of three, widespread (I).	02070		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns;	02170		

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02170	Continued From page 96 (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a comprehensive evaluation for activities and an individual activity plan (IAP) for one of three residents (R6) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02170			

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02170	Continued From page 97 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R6's diagnoses included vascular dementia, personality disorder, and obsessive compulsive disorder. R6's Individual Activity Plan dated March 22, 2023, lacked the following required content: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R6's record lacked the development of an individualized activity plan based on the activity evaluation. On March 22, 2023, at 11:25 a.m. clinical nurse supervisor (CNS)-C confirmed R6's IAP was completed after the evaluators entered on March 20, 2023. CNS-C reviewed R6's IAP and confirmed R6's IAP was not a comprehensive activity evaluation and further lacked the development of an activity plan.	02170			

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02170	Continued From page 98 The licensee's Life Enrichment policy dated August 1, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: o past and current interests; o current abilities and skills; o emotional and social needs and patterns; o physical abilities and limitations; o adaptations necessary for the resident to participate; o identification of activities for behavioral interventions; and an individualized activity plan must be developed for each resident based on their activity evaluation and must reflect the resident's activity preferences and needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
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 the care and services were provided according to acceptable health care and medical, or nursing standards for one of three residents (R1) with an assistive device of hospital-style bed rails. In addition,	02310		

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02310	Continued From page 99 based on observation and interview the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for three of seventeen oxygen tanks. 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: This resulted in an immediate correction order identified on March 22, 2023. The findings include: R1's diagnoses include abdominal aortic aneurysm without rupture (enlarged, the main blood vessel that delivers blood to the body", history of CVA (stroke), and diabetes. R1's service plan dated March 6, 2023, indicated R1 received the following services: medication administration seven times daily, dressing assist, blood glucose checks four times daily, blood pressure monitoring daily, special dressing three times daily, oxygen saturations twice daily, pulse monitoring twice daily, temperature twice daily, toileting reminder fourteen times daily, transfer assistance three times daily, assistance with bathing twice weekly, behavior management three times daily, and housekeeping services.	02310			

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02310	Continued From page 100 R1's assessment dated January 11, 2023, indicated R1 had her own bed from home with original mattress; with no bed adaptations, no side rails raised, or grab bar on bed for safety and/or comfort. In addition to lack of assessment of side rails, R1's record lacked documentation of a risks versus benefits discussion and education. On March 21, 2023, at 7:40 a.m., the evaluator observed R1 laying in a hospital bed with half side rails on both sides of the bed, in the raised position. The evaluator observed unlicensed personnel (ULP)-F and registered nurse (RN)-J transfer R1 from bed to wheel chair using a Best Care sit to stand transfer device (mechanical lift). On March 21, 2023, at 1:09 p.m., RN-B stated "I'll just be honest with you", there is no bed rail assessment for R1. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of	02310			

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02310	Continued From page 101 bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's Mobility Bar (Grab Bar, Halo Bar, Side Rail, Bed Rails) policy dated August 1, 2021, indicated when this licensee was aware a resident was utilizing a mobility bar (a medical device) on a bed, the licensee shall assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the mobility bar in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the siderail. Further, the policy indicated staff from the licensee shall determine if the mobility bar is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: A. The mobility bar is used consistent with manufacturer's directions. Be aware of mobility bars that slide between the mattress and box spring designed for toddler use only. B. The mobility bars are installed to the manufacturer's recommendations securely, and maintained in good operating condition. Be aware of "wobbly" mobility bars. C. The mobility bar design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. In addition, the licensee shall inform local known hospice providers and known medical equipment suppliers that residents of the licensee would only be permitted to use mobility bars only that comply with the 2006 FDA dimensional guidance to reduce entrapments. Assessments and education procedures must still be followed.	02310			

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02310	Continued From page 102 No additional information was provided TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyors' on-site observation and review by evaluation supervisor on March 23, 2023, however, non-compliance remains at a scope and level of three, isolated (G). OXYGEN TANK STORAGE On March 20, 2023, at approximately 1:00 p.m., during a tour of the secured unit, the evaluator observed a door titled "oxygen room". In the oxygen room were four (4) large oxygen tanks in a metal storage rack and one (1) large oxygen tank unsecured. On March 20, 2023, directly following the above observation RN-B stated the unsecured oxygen tank should have been secured, adding she was not sure why it was not secured. R4's diagnoses included chronic obstructive pulmonary disease (COPD/a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) and heart failure. R4's service plan dated December 27, 2022, included oxygen delivery three times per day, daily. On March 21, 2023, at approximately 8:15 a.m., the evaluator observed ULP-F administer R4's morning oral medication, nebulizer and eye medication. R4 was wearing a nasal cannula which was attached to an oxygen concentrator positioned near his bed.	02310			

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02310	Continued From page 103 On March 23, 2023, at 11:13 a.m., the evaluator observed ten (10) large oxygen tanks in R4's room secured, one large (1) tank unsecured, and one (1) ex-large oxygen tank unsecured. On March 23, 2023, at 11:14 a.m., clinical nurse supervisor (CNS)-C stated all R4's oxygen tanks were "supposed to be in a rack." Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. The licensee's Oxygen policy dated August 1, 2021, indicated oxygen cylinders and vessels must remain upright at all times in a tank holder. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02370 SS=I	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure 10 of 18 residents (R8, R17, R19, R20, R21, R22, R23,	02370			

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02370	Continued From page 104 R24, R25, R26) had the right to enter and leave the facility as they chose. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia license for a resident capacity of 70. Upper Shiloh house was a secured house which required code for the keypad to exit the house. Per Minnesota Assisted Living: Chapter 144G, 144G.08, Subd. 62, "Secured dementia care unit" means a designated are or setting designed for individuals with dementia that is locked or secured to prevent a resident from exiting, or to limit a resident's ability to exit, the secured setting. A secured dementia care unit is not solely an individual resident's living area. During entrance conference on March 20, 2023, at 10:48 a.m., registered nurse (RN)-B stated all residents received the Minnesota Assisted Living Bill of Right upon admission. R8 R8 Face Sheet indicate R8 was admitted August 7, 2019. R8's diagnoses included major depression, delusional disorder, delusional thoughts, posttraumatic stress disorder (PTSD),	02370			

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02370	Continued From page 105 sleep apnea, hypertension (high blood pressure), diabetes, chronic obstructive pulmonary disease (COPD), and shortness of breath. R8 did not have a dementia related diagnosis. R8's service plan dated June 28, 2022, indicated R8 received services to include activity assistance, bathing, dressing, grooming, toileting reminders, medication administration, oxygen management, behavior management, housekeeping, and laundry. R8's comprehensive assessment dated December 26, 2022, indicated R8 was not at risk for wandering or elopement. R8's Individual Abuse Prevention Plan (IAPP) dated December 26, 2022, R8 had delusional thoughts, depression, and R8's mental health was controlled with medications. R8 was not at risk to abuse other vulnerable adults or themselves. R8 had a representative to assist with financial matters. R8 was independent with making own health care decisions and did not have a guardian or power of attorney (POA). R8 did not have the code to leave the secured house freely. R17 R17's Face Sheet indicated R17 was admitted August 1, 2018. R17's diagnoses included bipolar disorder, paranoid schizophrenia, hypertension, alcohol abuse, chronic pain, and renal (kidney) failure. R17 did not have a dementia related diagnosis. R17's service plan dated August 22, 2022, indicated R17 received services to include activity assistance, bathing, dressing, grooming, meal	02370			

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02370	Continued From page 106 reminders, medication administration, behavior management, safety checks, housekeeping, and laundry. R17's comprehensive assessment dated January 23, 2023, had a rep payee (a person appointed by Social Security Administration to man benefit payments) and a legal guardian to manage health care decisions. R17 was orientated to person, place and time. R17 did not have restrictions to rights regarding visitors, social participation, personal and treatment privacy, or access to food. R17 did not have a pattern of wandering. R17's IAPP dated January 23, 2023, indicated R17 was at risk for elopement and interventions were to monitor R17 hourly. R17 was at risk to abuse other vulnerable adults, had a history of suicidal ideation but was not at risk to abuse themselves. R17 had a history of sexual inappropriateness to staff and residents and interventions included hourly safety checks. On March 22, 2023, at 3:31 p.m., R17 stated he had been living at the facility for about nine (9) years and had moved to different buildings of the licensee over the course of the years including the assisted living. R17 stated since he moved into the secured house, he had been unable to leave the house freely and wished he could go into town to a local tavern, that he had never been to before. R17 did not have the code to leave the secured house freely. R19 R19's Face Sheet indicated R19 was admitted August 1, 2018. R19's diagnoses included disorganized schizophrenia, depressive disorder,	02370			

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02370	Continued From page 107 psychosis in elderly, and hypertension. R19 did not have a dementia related diagnosis. R19's service plan dated August 3, 2022, received services to include activity assistance, bathing, dressing, grooming, skin care, meal reminders, medication administration, behavior management, safety checks, housekeeping, and laundry. R19's comprehensive assessment dated February 23, 2023, indicated R19 had a guardian to assist with financial matters, health care services and decision making. R19 had no restrictions to R19's rights regarding visitors, social participation, personal and treatment policy or access to food. R19's behaviors included delusions about war and racist behaviors against residents of color. R19's behaviors were stable with current medication regimen. R19 was orientated to person and place. R19 was not at risk for elopement or wandering. R19's IAPP dated February 23, 2023, indicated was at risk to abuse other vulnerable adults and interventions included to monitor hourly. R19 was not at risk to abuse themselves, and had impaired judgement related to mental health diagnoses. R19 did not have the code to leave the secured house freely. R20 R20's Face Sheet indicated R20 was admitted August 1, 2018. R20's diagnoses included personality and behavioral disorders, depression, Rasmussen encephalitis (a rare disorder of the central nervous system), hemiparesis (weakness on one side of the body), hypertension,	02370			

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02370	Continued From page 108 osteoporosis, and generalized weakness. R20 did not have a dementia related diagnosis. R20's service plan dated August 19, 2022, received services to include activity assistance, bathing, toileting, transferring, dressing, grooming, meal assistance, medication administration, brace application, behavior management, safety checks, housekeeping, and laundry. R20's comprehensive assessment dated March 17, 2023, indicated R20's family member was R20's guardian to manage financial matters and decision making. R20 had no restrictions to rights regarding visitors, social participation, personal and treatment privacy or access to food. R20 was not at risk for elopement or wandering and no recent episodes of hallucinations. R20's IAPP dated March 17, 2023, indicated R20 was not at risk to abuse other vulnerable adults or risk to abuse themselves. R20 had impaired judgement due to mental health diagnoses and cognitive impairment. R20's mental health was being managed with current medication regimen. R20 did not have the code to leave the secured house freely. R21 R21's Face Sheet indicated R21 was admitted November 1, 2018. R21's diagnoses included delusional disorder, anxiety, history of alcohol use, insomnia, atrial fibrillation (irregular heartbeat), and hypertension. R21 did not have a dementia related diagnosis. R21's service plan dated August 8, 2022, received services to include activity assistance,	02370			

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02370	Continued From page 109 bathing, dressing, grooming, meal reminders, medication administration, blood glucose monitoring, behavior management, safety checks, housekeeping, and laundry. R21's comprehensive assessment dated April 2, 2023, indicated R21 was independent with financial and health care decisions. R21 was orientated to person, place and time. R21 was not at risk for elopement or wandering. R21's mental health was being managed with current medication regimen. R21's IAPP dated April 2, 2023, indicated R21 was not at risk to abuse other vulnerable adults or themselves and had impaired judgement related to mental health diagnoses. R21 did not have the code to leave the secured house freely. R22 R22's Face Sheet indicated R22 was admitted December 21, 2020. R22's diagnoses included schizophrenia, acute renal failure, hypertension, diabetes, history of seizures, and insomnia. R22 did not have a dementia related diagnosis. R22's service plan dated August 8, 2022, received services to include activity assistance, bathing, dressing, grooming, meal reminders, medication administration, behavior management, safety checks, housekeeping, and laundry. R22's comprehensive assessment dated February 13, 2023, indicated R22 had a rep payee to manage financial matters, R22 was independent with health care decisions. R22 had delusional behaviors and was currently stable on	02370			

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02370	Continued From page 110 medication regimen. R22 was not at risk of elopement or wandering. R22's IAPP dated February 13, 2013, indicated R22 was not at risk to abuse other vulnerable adults or themselves. R22 had impaired judgement and was disorientated to time. R22's mental health was being managed with current medication regimen. R22 did not have the code to leave the secured house freely. R23 R23's Face Sheet indicated R23 was admitted February 21, 2023. R23's diagnoses included of paranoid schizophrenia, acute kidney injury (sudden episode of kidney failure), and benign prostatic hyperplasia (BPH-enlarge prostate). R23 did not have a dementia related diagnosis. R23's comprehensive assessment dated March 7, 2023, indicated R23 had no behavioral concerns, was disorientated to place, and time and R23's decision making skills were severely impaired. R23 was not at risk for elopement or wandering. R23's IAPP dated March 7, 2023, indicated R23 was not at risk to abuse other vulnerable adults or themselves and has no abusive or aggressive behaviors. R23 had difficulty weighing advice due to psychiatric diagnoses. R23's service plan was requested and not provided. R23 did not have the code to leave the secured house freely.	02370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34980	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/24/2023
NAME OF PROVIDER OR SUPPLIER SHILOH ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5384 COUNTRY CARE LANE PEQUOT LAKES, MN 56472		
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02370	Continued From page 111 R24 R24's Face Sheet indicated R24 was admitted November 11, 2018. R24's diagnoses included cerebrovascular accident (CVA-stroke), aphasia (disorder that affects speech), alcoholism, anxiety, depression, history of prostate cancer, and hypertension. R24 did not have a dementia related diagnosis. R24's service plan dated March 2, 2023, indicated R24 received services to include activity assistance, bathing, dressing, grooming, toileting, medication administration, meal assistance, behavior management, housekeeping, and laundry. R24's comprehensive assessment dated February 24, 2023, indicated had a rep payee to manage financial matters and R24 was independent in making own health care decisions. R24's behaviors included refusal of toileting and hygiene cares and had occasional agitation with staff. R24's behaviors were re-directable and stable with current medication regimen. R24 was not at risk for elopement or wandering. R24's IAPP dated February 24, 2023, indicated R24 was at risk to abuse other vulnerable adults and was a level two (2) sex offender (non-violent sex crimes involving a minor). Interventions included a secured unit and follow up with the local police department. R24 was occasionally disorientated to place and time. R24 did not have the code to leave the secured house freely. R25 R25's Face Sheet indicated R25 was admitted	02370		

Minnesota Department of Health

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02370	Continued From page 112 August 1, 2018. R25's diagnoses included of paranoid schizophrenia, hypertension, hyperlipidemia (high cholesterol level), and hearing loss in right ear. R25 did not have a dementia related diagnosis. R25's service plan dated August 3, 2022, received services to include activity assistance, bathing, dressing, grooming, meal assistance, medication administration, behavior management, safety checks, housekeeping, and laundry. R25's comprehensive assessment dated January 11, 2023, indicated R25 had a guardian for financial and health care service decisions. R25 was orientated to person, place, and time, and was not at risk for elopement or wandering. R25's IAPP dated January 11, 2023, indicated R2 was not at risk to abuse others or themselves. R25 had impaired judgement related to mental health diagnoses and orientation varies with mental health and delusions. R25 did not have the code to leave the secured house freely. R26 R26's Face Sheet indicated R26 was admitted August 1, 2018. R26's diagnoses included schizophrenia, bipolar, psychotic disorder, atrial fibrillation, chronic pain, and wheelchair bound. R26 did not have a dementia related diagnosis. R26's service plan was requested and not provided. R26's comprehensive assessment dated February 23, 2023, indicated R26 had a rep	02370			

Minnesota Department of Health

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02370	Continued From page 113 payee to manage financial matters and was independent with health care decisions. R26 did not have a guardian, was committed, and had a Jarvis order (gives court the power to order medication for a committed person who refuses to take prescribed psychiatric medications). R26 has a history of elopement from other facilities and interventions include being in a locked unit and hourly safety checks. R26's IAPP dated February 23, 2023, indicated R26 was at risk to abuse other vulnerable adults and self due to poor self-care awareness and refusing grooming and hygiene cares. R26 had impaired judgment due to psychiatric disorders. R26 did not have the code to leave the secured house freely. On March 21, 2023, at 8:48 a.m., licensed assisted living director (LALD)-A stated all the residents who currently resided in the secured house had a diagnosis of dementia. LALD-A stated having memory issues was not a requirement to live in the secured house and some residents in the secure house had mental health illnesses like schizophrenia, were sex offenders, a flight risk or were ordered to be there by the court. LALD-A stated all the residents currently residing in the secured unit needed to be there for safety their own safety. On March 21, 2023, at 9:56 a.m., activities coordinator (AC)-I stated she usually did the shopping for the residents in the secured house since the residents were unable to get out and do their own shopping. AC-I stated the shopping day was listed on the activity calendar and residents provided her with a shopping list and she purchased the requested items for the residents.	02370			

Minnesota Department of Health

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02370	Continued From page 114 On March 21, 2023, at 12:47 p.m., RN-B stated the secured house was not a memory care unit rather a secured or locked unit. RN-B stated the criteria for admission was having a dementia diagnosis, wandering or exit seeking behaviors, were an elopement risk, had increased behaviors, mental illness diagnoses, court ordered, requested by their guardians or county case managers. RN-B further stated the licensee had a contract with a treatment center to take in individuals who were unable to live in the community unsupervised and required a secured setting. RN-B stated there were no residents in the secured house that could leave on their own or had the access code to exit the house. On March 22, 2023, at 2:58 p.m. unlicensed personnel (ULP)-M stated residents were not allowed to leave the building freely and did not have the access code to the keypad to exit. ULP-M stated there were no current residents who attempt to exit the building. On March 22, 2023, at 3:44 p.m., LALD-A stated residents were not able to leave the secured house freely or were allowed to have the access code to exit the building. LALD-A further stated, "if they were given the code, they wouldn't remember the code anyway." On March 23, 2023, at 11:30 a.m., RN-B stated residents who had a dementia diagnoses or dementia related diagnosis were housed in the secured unit either because they were convicted sex offenders and it was it was a requirement for discharge to be in a secured environment, they were court ordered, or it was determined by their county case manager a secured house would be beneficial for the resident's safety. Clinical nurse	02370			

Minnesota Department of Health

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02370	Continued From page 115 supervisor (CNS)-C stated assessment of the resident did not determine if a resident required a secured house. CNS-C stated most of the residents in the secure house were either there due to a condition of release, had mental health behavioral concerns and were placed in a secured environment by the resident's county case manager or guardian. RN-B further stated residents who had mental health diagnoses had referrals in their medical record to support the need for a secure environment. On March 23, 2023, at 2:10 p.m., agent (A)-N stated the residents in the secured unit had guardians and the guardians decided if the residents required a secured environment, not the residents. The surveyor received the residents' hard charts containing medical records to review. After review of the resident paper charts, information reviewed in the chart dated back to 2018 and did not include referrals or information regarding the need for a secured living environment. The licensee's Protecting Resident Rights policy revised July 26, 2022, indicated prior to, or at the time of admission, all residents would be provided a copy of the Minnesota Assisted Living Bill of Rights. The Minnesota Bill of Rights for Assisted Living Residents dated November 28, 2022, under the Right to come and go freely, indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. No further information provided.	02370			

Minnesota Department of Health

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02370	Continued From page 116 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02370		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, and interview the licensee failed to ensure signage was posted at the main entry in one of two buildings (secured) of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 18 residents, staff and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 20, 2023, at 1:00 p.m., the evaluator entered the secured building of the campus and observed no signage posted at the entrance or areas immediately adjacent to the entry regarding	03090		

Minnesota Department of Health

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03090	Continued From page 117 electronic monitoring. On March 20, 2023, at 1:05 p.m., registered nurse (RN)-B confirmed there was no electronic monitoring signage posted at the secured building. RN-B stated someone took the sign down, adding there was a sign there. RN-B stated there were no cameras in the building. The licensee's Electronic Monitoring policy dated August 1, 2021, stated signs were installed at each community entrance accessible to visitors stating the following: Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) day	03090			

Type: Full
Date: 03/20/23
Time: 12:00:00
Report: 6808231078

Food and Beverage Establishment Inspection Report

Page 1

Location:

Shiloh Assisted Living
5384 Country Care Lane
Pequot Lakes, MN56472
Crow Wing County, 18

Establishment Info:

ID #: 0038774
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185684673
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE NEW BATTERIES FOR THE DISHWASHER THERMOMETERS IN BOTH THE SHILOH AND THE UPPER DAKOTA KITCHENS.

Comply By: 03/23/23

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

PROVIDE LIGHT SHIELDS FOR THE LIGHTS IN THE KITCHEN AND STORAGE AREAS AT UPPER DAKOTA.

Comply By: 03/31/23

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit

Location: FINAL RINSE DISH TEMPERATURE IN DISHWASHER AT SHILOH

Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit

Location: FINAL RINSE DISH TEMPERATURE IN DISHWASHER AT UPPER DAKOTA

Violation Issued: No

Type: Full
Date: 03/20/23
Time: 12:00:00
Report: 6808231078
Shiloh Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

Food and Equipment Temperatures

Process/Item: Upright Cooler

Temperature: 39 Degrees Fahrenheit - Location: RICE IN 2-DOOR AT SHILOH

Violation Issued: No

Process/Item: Steam Table

Temperature: 158 Degrees Fahrenheit - Location: GRAVY AT SHILOH

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 39 Degrees Fahrenheit - Location: CHEESECAKE IN 2-DOOR IN NEW KITCHEN

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 38 Degrees Fahrenheit - Location: HOTDISH IN 2-DOOR AT UPPER DAKOTA

Violation Issued: No

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

THE NEW (THIRD) KITCHEN IN THE NEW BUILDING WAS CONSTRUCTED ACCORDING TO THE PLANS APPROVED IN 2021.

INSPECTED ALL THREE KITCHENS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 6808231078 of 03/20/23.

Certified Food Protection Manager Michael Nelson

Certification Number: _____ Expires: 01/20/25

Signed: _____

Establishment Representative

Signed: Lee Ann Austin

Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us