



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 29, 2024

Licensee
Evansville Senior Living
651 State Street Northwest
Evansville, MN 56326

RE: Project Number(s) SL30540015

Dear Licensee:

On September 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 18, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Benjamin Zwart'.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290



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July 8, 2024

Licensee
Evansville Senior Living
651 State Street Northwest
Evansville, MN 56326

RE: Project Number(s) SL30540015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,

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

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30540	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER EVANSVILLE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 651 STATE STREET NW EVANSVILLE, MN 56326			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30540015 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine residents; four receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two 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 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:	0 660			

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0 660	Continued From page 2 The facility's TB risk assessment was completed on October 4, 2023, and the facility was determined to be a low risk level. CNS-B was hired on March 1, 2024, to provide direct care services to residents and supervision of staff at the assisted living facility. CNS-B's employee record contained a negative TST dated August 21, 2008. CNS-B's employee record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test. On June 18, 2024, at 11:10 a.m., CNS-B stated CNS-B did not recall completing a two-step TST upon being hired for employment at the associated campus of the assisted living. On June 18, 2024, at 11:28 a.m., licensed assisted living director/license practical nurse (LALD/LPN)-A stated the licensee was aware of the requirement to complete a two-step TST or other evidence of TB screening upon staff being hired. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated new staff will have an IGRA blood test or a two-step mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs (health care workers) [sic]. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.	0 660			

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

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0 680	Continued From page 4 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 17, 2024, at 9:59 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Emergency Preparedness Plan (EPP) indicated the last review date was January 14, 2024. The Missing Resident Plan contained in the EPP lacked evidence the policy had been reviewed quarterly, as required. On June 18, 2024, at 11:22 a.m., LALD/LPN-A stated the missing resident policy was reviewed annually with the emergency preparedness plan. LALD/LPN-A further stated the licensee was not aware of the requirement to review the missing resident policy at least quarterly. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated (licensee name) will review this policy (missing resident policy) and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules	0 680			

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0 680	Continued From page 5 Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 17, 2024, at 2:10 p.m., with maintenance director (MD)-C, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the MD-C explained that resident rooms #101, #102, #114, #115, #116 and #117 are on a different smoke alarm system than resident rooms #103, #104, #105, #106, #107, #108, #109, #110, #111 and #112. The rest of the facility had single battery powered smoke alarms that ran throughout to include the main hallways, kitchen, and dining area. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780			

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0 810	Continued From page 7	0 810			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810			

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0 810	Continued From page 8 Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. 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). The findings include: On June 17, 2024, at 2:42 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A and maintenance director (MD)-C provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan needs to be updated to the facilities current setup. Record review of the available documentation	0 810			

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0 810	Continued From page 9 indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed one evacuation drill in January and one in May of 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (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	01470			

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01470	Continued From page 10 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees (registered nurse (RN)-G, RN-F). This had the potential to affect all nine	01470			

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01470	Continued From page 11 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 17, 2024, at 10:13 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was aware of required contents for an employee record. The licensee had an approved innovation variance issued by the Minnesota Department of Health to allow employees of the connected skilled nursing facility to meet emergency needs only of residents between 7:30 p.m. through 7:30 a.m. RN-G RN-G was employed at the skilled nursing facility since September 5, 2022, and was an RN available to answer pendant call lights for the residents at the assisted living facility under the licensee's approved variance. RN-G's employee record lacked the following required orientation content: -an overview of chapter 144G; -handling of emergencies and use of emergency services; -the assisted living bill of rights and staff	01470			

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NAME OF PROVIDER OR SUPPLIER EVANSVILLE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 651 STATE STREET NW EVANSVILLE, MN 56326		
(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
01470	Continued From page 12 responsibilities related to ensuring the exercise and protection of those rights; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. RN-F RN-F was employed at the skilled nursing facility since May 30, 2019, and was an RN available to answer pendant call lights for residents at the assisted living facility under the licensee's approved variance. RN-F's employee record included a Job Description Addendum dated January 5, 2024, that indicated care center staff will be required to respond/assist in the event of an emergency at the (facility name) for emergency purposes only, no cares will be provided by the care center staff. RN-F's employee record lacked the following required orientation content: -an overview of chapter 144G; -handling of emergencies and use of emergency services; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470			

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01470	Continued From page 13 Ombudsman at the Department of Human Services, county-managed care advocates, or other advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 18, 2024, at 11:43 a.m., LALD/LPN-A stated RN-G and RN-F did not complete the entire content of orientation to assisted living and were not assigned the assisted living orientation in the licensee's online training program. LALD/LPN-A stated the licensee did not think it was required since evening and overnight staff from the care center did not provide scheduled cares to residents at the facility, however, LALD/LPN-A confirmed care center staff would respond to all resident pendant call lights, whether emergency or non-emergency, from 7:30 p.m. until 7:30 a.m. daily. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated August 1, 2021, indicated orientation (orientation to assisted living) must be completed once for each staff person before providing assisted living services to residents and included all above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640			

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01640	Continued From page 14 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 the service plan included a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R3). This practice resulted in a level two 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 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:	01640			

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01640	Continued From page 15 During the entrance conference on June 17, 2024, at 9:59 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. On June 18, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-E administer scheduled morning insulin to R3. R3's service plan dated July 1, 2023, indicated services included medication administration, mediation setup, laundry, and housekeeping. R3's service plan did not include a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On June 18, 2024, at 11:56 a.m., LALD/LPN-A stated the licensee did not authenticate R3's service plan. LALD/LPN-A further stated the licensee's process was to have the registered nurse (RN) sign the service plan at the same time as the resident. The licensee's 6.10 Service Plan Modifications policy dated August 1, 2021, indicated if the service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service Plan Modification form will be completed; this form includes Date/Signature [sic] of RN making changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01710	Continued From page 16	01710			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R4) who received medication management services. This practice resulted in a level two 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on June 17, 2024, at 10:02 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management to residents at the facility. R4's diagnoses included chronic obstructive pulmonary disease (COPD) and hypertension	01710			

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01710	Continued From page 17 (HTN-high blood pressure). R4's service plan dated January 10, 2024, indicated services included medication administration. R4's prescriber orders dated January 10, 2024, included three antihypertensives, one to treat allergies, four supplements, and one to treat restless leg syndrome. On June 18, 2024, at 7:48 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R4's scheduled morning medications. During the observation, the surveyor observed a bottle of ibuprofen on R4's kitchen counter. On June 18, 2024, at 8:16 a.m., ULP-E stated R4 took as needed (PRN) medications independently. R4's Individualized Medication Management Plan dated January 10, 2024, indicated medication administration by facility staff. R4's record indicated a face-to-face medication administration assessment had been completed on January 10, 2024, and included medications listed on the Electronic Medication Record (EMAR). R4's ibuprofen was not listed on the EMAR or prescriber orders. R4's record lacked a face-to-face medication administration reassessment after R4 had begun taking ibuprofen as needed. On June 18, 2024, at 12:15 p.m., LALD/LPN-A stated R4's record lacked a reassessment of medications if R4 had begun taking ibuprofen as needed and a medication reassessment should	01710			

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01710	Continued From page 18 have been completed. LALD/LPN-A further stated the licensee was not aware R4 had ibuprofen in R4's apartment and the licensee should have obtained a prescriber order for R4 to self-administer ibuprofen. The licensee's 7.01 Medication Management-Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated the licensee will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730			

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01730	Continued From page 19 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of two residents (R3, 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	01730			

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01730	Continued From page 20 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 17, 2024, at 10:02 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management to residents at the facility. R3 R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), and osteoarthritis. R3's service plan dated July 1, 2023, indicated services included medication administration. R3's prescriber orders dated June 14, 2024, included two heart medications, one antihypertensive, one antidepressant, one antidiuretic, two to treat pain, one antihyperlipidemic, two to lower blood sugars, one to treat acid reflux, and one to treat constipation. On June 18, 2024, at 9:02 a.m., the surveyor observed unlicensed personnel (ULP)-E administer scheduled morning insulin to R3. During the observation, the surveyor observed R3's medications stored in R3's room. R3's Individualized Medication Management Plan dated April 3, 2024, indicated the resident was able to safely store all medications independently, medications are stored in a locked medication cart, and medications set up by nurse are stored in locked med (medication) cart.	01730			

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01730	Continued From page 21 R4 R4's diagnoses included chronic obstructive pulmonary disease (COPD) and HTN. R4's service plan dated January 10, 2024, indicated services included medication administration. R4's prescriber orders dated January 10, 2024, included three antihypertensives, one to treat allergies, four supplements, and one to treat restless leg syndrome. On June 18, 2024, at 7:48 a.m., the surveyor observed ULP-E administer R4's scheduled morning medications. During the observation, the surveyor observed a bottle of ibuprofen on R4's kitchen counter. R4's Individualized Medication Management Plan dated January 10, 2024, indicated medications are stored in a locked medication cart. R3 and R4's individualized medication management plans did not match current medication storage for each resident. On June 18, 2024, at 12:03 p.m., LALD/LPN-A stated R3 and R4's individual medication management plan did not reflect medication storage for each resident correctly. LALD/LPN-A stated the licensee was aware individual medication management plans need to be updated with any changes. CNS-B nodded CNS-B's head up and down in agreement to LALD/LPN-A's statement. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a	01730			

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01730	Continued From page 22 current individualized medication management record for each resident based on the resident's assessment that included a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. The medication management record will be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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).	01880			

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01880	Continued From page 23 The findings include: During the entrance conference on June 17, 2024, at 10:02 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management to residents at the facility. On June 18, 2024, at 9:05 a.m., unlicensed personnel (ULP)-E stated R3's refrigerator temperature was not monitored since it was R3's private refrigerator. R3's refrigerator contained 10 unopened Tresiba 100 units/milliliter (mL) FlexTouch insulin pens. On June 18, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-B stated medications should be stored per manufacturer's instructions and would not know if R3's insulin was being stored properly due to not monitoring R3's refrigerator temperature. CNS-B further stated the licensee did not monitor the temperature of any refrigerator that stored resident's medications. The manufacturer's instructions for Tresiba FlexTouch insulin pen dated March 2018, indicated to store unused Tresiba in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880			

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01880	Continued From page 24 days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the open date and expiration date for time sensitive medications for one of one resident (R3). This practice resulted in a level two 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on June 17, 2024, at 10:02 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management to residents at the facility. On June 18, 2024, at 9:02 a.m., the surveyor	01890			

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01890	Continued From page 25 observed unlicensed personnel (ULP)-E administer scheduled morning insulin to R3. R3's Tresiba 100 units/milliliters (mL) FlexTouch pen (a multiple dose pen shaped injector device for insulin administration) did not indicate when the insulin pen was opened, and when the insulin pen would expire. ULP-E stated R3's insulin pen was not labeled with the open date or expiration date since R3 used the insulin every day and the insulin pen should be out of insulin before the insulin pen would expire. On June 18, 2024, at 11:17 a.m., clinical nurse supervisor (CNS)-B stated ULPs should document the open date and expiration date on R3's insulin pens. The manufacturer's instructions for Tresiba FlexTouch insulin pens dated March 2018, indicated to discard the insulin pen after 56 days even if it still has insulin left in it and the expiration date has not passed. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



MN Department of Health
Food, Pools, and Lodging Services
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St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: 06/18/24
Time: 13:57:23
Report: 7935241018

Food and Beverage Establishment Inspection Report

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Location:

Evansville Senior Living
651 State Street Nw
Evansville, MN56326
Douglas County, 21

Establishment Info:

ID #: 0038323
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189482346
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 186 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 179 Degrees Fahrenheit - Location: BBQ
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241018 of 06/18/24.

Certified Food Protection Manager: Melissa Englund

Certification Number: 89948 Expires: 07/16/26

Signed: _____

Establishment Representative

Signed:  _____

Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us