Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

May 11, 2023

Licensee
Birchview Gardens Assisted Living, Inc.
108 3rd Street North
Hackensack, MN 56452

RE: Initial License Number 408796
Health Facility Identification Number (HFID) 28209
Project Number(s) SL28209015

Dear Licensee:

On May 4, 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 November 10, 2022. 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 May 5, 2023.

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,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Full
Date: *05/01/23*
Time: 10:45:38
Report: 8046231046

Food and Beverage Establishment Inspection Report

Location:
Birchview Gardens Assisted Liv
108 3rd Street North
Hackensack, MN56452
Cass County, 11

Establishment Info:
ID #: 0038002
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202931472
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

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: MIXER VALVE
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: DISH CONTACT
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cooling
Temperature: 108 Degrees Fahrenheit - Location: SLOPPY JOES
Violation Issued: No

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: RICE
Violation Issued: No

Process/Item: Cooking
Temperature: 170 Degrees Fahrenheit - Location: REFRIED BEANS
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

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 8046231046 of 05/01/23.

Certified Food Protection Manager:____________________

Certification Number: __________ Expires: / /

Signed:____________________
Establishment Representative

Signed: Zach Johnson
Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENED CONDITIONAL LICENSE AND SURVEY RESULTS

Electronically Delivered

March 14, 2023

Licensee
Birchview Gardens Assisted Living, Inc.
108 3rd Street North
Hackensack, MN 56452

RE: Conditional License Number 408796
Health Facility Identification Number (HFID) 28209
Project Number(s) SL28209015 and HL282094364M/HL282097395C

Dear Licensee:

On February 7, 2023, the Minnesota Department of Health (MDH), State Evaluation Team completed a follow-up licensing evaluation of your facility to determine correction of orders found on the licensing evaluation completed on November 10, 2022. The follow-up licensing evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the November 10, 2022, evaluation.

In addition, MDH, State Rapid Response Team completed a complaint evaluation on February 21, 2023, for complaint HL282094364M/HL282097395C. The complaint evaluation determined the licensee was responsible for an instance of substantiated maltreatment. Please refer to the attached documents included in the same email for details of the complaint evaluation.

Based on the follow-up licensing evaluation and the complaint evaluation, you continue to not be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is extending the conditional license 60-days, due to expire on **May 13, 2023.**

LICENSING ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last licensing evaluation completed on November 10, 2022, found not corrected at the time of the February 7, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

St - 0 - 0250 - 144g.20 Subdivision 1 - Conditions - $500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $500.00
St - 0 - 0910 - 144g.50 Subd. 2 (a-B) - Contract Information
St - 0 - 0920 - 144g.50 Subd. 2 (c) - Contract Information
St - 0 - 0930 - 144g.50 Subd. 2 (d-E; 1-4) - Contract Information
St - 0 - 0940 - 144g.50 Subd. 2 (e; 5-7) - Contract Information
St - 0 - 0950 - 144g.50 Subd. 3 - Designation Of Representative - $500.00
St - 0 - 0970 - 144g.50 Subd. 5 - Waivers Of Liability Prohibited
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication
St - 0 - 1890 - 144g.71 Subd. 20 - Prescription Drugs
St - 0 - 2040 - 144g.81 Subdivision 1 - Fire Protection And Physical Environment - $500.00

St - 0 - 2110 - 144g.82 Subd. 3 - Policies - $500.00
St - 0 - 2290 - 144g.91 Subd. 2 - Legislative Intent - $500.00

The total amount you are assessed is $4,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

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 the Department of Health 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

CONDITIONAL LICENSE ISSUED:
MDH is issuing Birchview Gardens Assisted Living, Inc. an extension to the conditional assisted living facility license by an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Birchview Gardens Assisted Living, Inc. is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations are initiated 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: Birchview Gardens Assisted Living, Inc.** will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition.

c. **Consultant: Birchview Gardens Assisted Living, Inc.** will continue to contract with an RN to provide consultation concerning all resident(s) to whom Birchview Gardens Assisted Living, Inc. provides licensed assisted living services under the conditional license. The consultant must continue to have access to all resident(s) receiving services from Birchview Gardens Assisted Living, Inc. The consultant will continue to 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. Birchview Gardens Assisted Living, Inc. will continue to be responsible for the expense of the contract with the RN. The main purpose of the consultant is to continue to provide guidance to Birchview Gardens Assisted Living, Inc. in an effort to help Birchview Gardens Assisted Living, Inc. 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. Birchview Gardens Assisted Living, Inc. will continue to 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 continue to provide MDH with regular reports. The reports will continue on a weekly basis until MDH notifies Birchview Gardens Assisted Living, Inc., and the RN consultant about a change. Each report will continue to be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will continue to include information such as:

   i. Progress towards correction of licensing 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 the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Birchview Gardens Assisted Living, Inc. to correct the violations cited during the evaluation as well as to determine the overall practice of Birchview Gardens Assisted Living, Inc. 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 Evaluation:** At the time of the follow-up evaluation, 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:** Birchview Gardens Assisted Living, Inc. will continue to 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

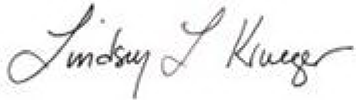
RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Birchview Gardens Assisted Living, Inc. is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the extended 60-day conditional license period. If MDH determines Birchview Gardens Assisted Living, Inc. is in substantial compliance on the follow up licensing evaluation and the follow up complaint evaluation, MDH will remove the conditions from Birchview Gardens Assisted Living, Inc.'s assisted living facility license. If MDH determines Birchview Gardens Assisted Living, Inc. is not in substantial compliance, MDH may take additional enforcement action against Birchview Gardens Assisted Living, Inc., including placement of additional conditions 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 (c), 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.

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.
Sincerely,



Lindsey Krueger, RN
Assistant Division Director

Minnesota Department of Health

Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	R 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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: SL28209015-1 On February 6, 2023, through February 7, 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 November 10, 2022. At the time of the survey, there were 37 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, correction orders 0250, 0510, 0780, 0800, 0910, 0920, 0930, 0940, 0950, 0970, 1620, 1640, 1760, 1890, 2040, 2110 and 2290 were reissued.	{0 000}	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.	
{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	{0 250}		

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{0 250}	Continued From page 1 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 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	{0 250}		

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{0 250}	Continued From page 2	{0 250}		

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) 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 revisit entrance conference on February 6, 2023, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated the licensee's

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{0 250}	Continued From page 3	{0 250}		

Continued From page 3

employees in charge of the facility were familiar with the assisted living 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.

- 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

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{0 250}	Continued From page 4	{0 250}		

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 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

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{0 250}	Continued From page 5	{0 250}		

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 LALD-A on May 23, 2021.

The licensee had an assisted living license issued on August 1, 2022, with an expiration date of September 30, 2023.

The licensee failed to ensure the following policies and procedures were developed and/or implemented:
(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;
(8) infection control practices; and
(9) medication and treatment management.

On November 10, 2022, at 3:03 p.m., LALD-A stated he lacked an understanding of 144G statutes for reporting of maltreatment of vulnerable adults, conducting and handling background studies on employees, orientation, training, and competency evaluations of staff, handling complaints regarding staff or services

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	28209	A. BUILDING: ______ B. WING ______	R 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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 6	{0 250}		

provided by staff, conducting initial evaluations of residents' needs and the providers' ability to provide those services, 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, infection control practices, medication and treatment management, delegation of tasks by registered nurses, and failed to implement corresponding policies and procedures, as required.

As a result of this survey, the following orders were issued 0250, 0510, 0780, 0800, 0910, 0920, 0930, 0940, 0950, 0970, 1620, 1640, 1760, 1890, 2040, 2110, and 2290 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.

{0 510} SS=F — 144G.41 Subd. 3 Infection control program — {0 510}

(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

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{0 510}	Continued From page 7	{0 510}		

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility. The deficient practice had the potential to affect all residents, employees, 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).

Findings include:

Clinical nurse supervisor (CNS)-B
On February 6, 2023, at approximately 9:30 a.m., CNS-B met with evaluators for an entrance conference and was observed going from area to area in the main entry of the facility with residents and staff present without wearing a medical grade facial mask.

ULP-K
On February 6, 2023, at approximately 9:30 a.m., the evaluator observed ULP-K sitting behind the front desk in the main entrance interacting with three residents. ULP-K stated she was the ULP administering medications for residents. ULP-K lacked the use of a medical grade facial mask.

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Housing Manager (HM)-F
On February 6, 2023, at approximately 9:45 a.m., the evaluator observed HM-F walking between HM-F's office and the main entry room, interacting with three residents present. HM-F lacked the use of a medical grade facial mask.

Registered nurse (RN)-C
On February 6, 2023, at approximately 9:45 a.m., the evaluator observed RN-C walking from the main entry area to various offices and interacting with three residents present. RN-C lacked the use of a medical grade facial mask.

During an interview on February 6, 2022, at 10:34 a.m., CNS-B confirmed the lack of medical grade facial mask use by herself, ULP-K, HM-F, and all other staff. CNS-B stated it "had been sometime" since medical grade masks had been worn.

February 6, 2022, at 10:34 a.m., the evaluator with CNS-B reviewed the Centers for Disease Control and Prevention (CDC) COVID-19 community transmission tracker website and CNS-B confirmed the CDC county tracker indicated covid transmission levels were high within the county the facility is located. CNS-B stated she was unaware of the high transmission rates and "no one here is sick." Additionally, CNS-B stated a part-time nurse employed by the licensee reviewed and monitored those things.

The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated November 2, 2022, indicated with high community transmission levels source control measures were recommended.

The licensee's COVID-19 Source Control Policy

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	and Procedure dated January 10, 2023, indicated source control was required for all staff while in the facility whenever they are in an area where they may encounter residents while community transmission rates are at a high level.			
	No further information was provided.			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}		
	(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;			
	This MN Requirement is not met as evidenced			

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{0 780}	Continued From page 10 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 9, 2023, between 10:40 a.m. and 12:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that when smoke alarms in resident apartments 4 and 7 were tested by the LALD-A, none of the other alarms within the dwelling unit were activated. During the facility tour interview, the LALD-A confirmed that smoke alarms were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate.	{0 780}		
{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.	{0 800}		

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{0 800}	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 9, 2023, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed a pressure relief valve without a discharge pipe in the mechanical room for resident apartment 3. During the facility tour interview, the LALD-A confirmed the findings.	{0 800}		
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider	{0 910}		

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when applicable;
(2) the licensee of the facility;
(3) the managing agent of the facility, if applicable; and
(4) the authorized agent for the facility.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022.

R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022.

R10's Assisted Living Contract effective August 1,

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{0 910}	Continued From page 13 2021, was signed by R10's guardian July 15, 2022. R1, R2, R3, R6, and R10's assisted living contracts lacked the following required content: - the HFID number (provider identification number); - the managing agent of the facility, if applicable; and - the authorized agent for the facility. On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator, were the original contracts that lacked the above noted items. A new contract draft, reviewed by the evaluator had been completed, however, had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed." No further information was provided.	{0 910}		
{0 920} SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional	{0 920}		

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fee;
(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;
(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;
(6) billing and payment procedures and requirements; and
(7) disclosure of the facility's ability to provide specialized diets.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1,

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{0 920}	Continued From page 15 2021, was signed by R3's power of attorney on February 24, 2022. R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022. R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022. R1, R2, R3, R6, and R10's assisted living contracts lacked the following required content: - disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator, were the original contracts that lacked the above noted items. A new contract draft, reviewed by the evaluator had been completed, however, had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed." No further information was provided.	{0 920}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to	{0 930}		

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residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.
(e) The contract must include a clear and conspicuous notice of:
(1) the right under section 144G.54 to appeal the termination of an assisted living contract;
(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;
(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;
(4) the resident's right to obtain services from an unaffiliated service provider;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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:

R1's Assisted Living Contract effective August 1,

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{0 930}	Continued From page 17 2021, was signed by the resident January 17, 2022. R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022. R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022. R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022. R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022. R1, R2, R3, R6 and R10's assisted living contracts lacked: - the name and contact information of the person representing the facility who is designated to handle and resolve complaints; - the right under section 144G.54 to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator, were the original contracts that lacked the above noted items. A new contract draft, reviewed by the evaluator had been completed, however, had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was	{0 930}		

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{0 930}	Continued From page 18 the week we had planned to get those signed." No further information was provided.	{0 930}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
{0 940}	Continued From page 19 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10). 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: R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022. R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022. R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022. R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022. R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022.	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 940}	Continued From page 20 R1, R2, R3, R6, and R10's Assisted Living Contracts all lacked disclosure of: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including; - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - a statement that medical assistance waivers provide payment for services but do not cover the cost of rent; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the toll-free number for the Minnesota Adult Abuse Reporting Center (MAARC). On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator, were the original contracts that lacked the above noted items. A new contract draft, reviewed by the evaluator had been completed, however, had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed."	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 940}	Continued From page 21 No further information was provided.	{0 940}		
{0 950} SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity	{0 950}		

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{0 950}	Continued From page 22	{0 950}		

to identify a designated representative in writing with the required statutory language for five of five residents (R1, R2, R3, R6, R10) with records reviewed.

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022.

R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022.

R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022.

R1, R2, R3, R6 and R10's Elderly Housing with Services Contract lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 950}	Continued From page 23 On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator were the original contracts that lacked the above noted requirement, and a new draft contract reviewed by the evaluator had been completed, however, had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed." No further information was provided.	{0 950}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living agreement did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	{0 970}		

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{0 970}	Continued From page 24	{0 970}		

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:

R1, R2, R3, R6, and R10's Assisted Living Contracts dated January 17, 2022, May 4, 2022, February 24, 2022, January 31, 2022, and July 15, 2022, respectively, contained two paragraph clauses indicating the resident would waive the facility's liability as follows:

"Section N - Personal Property. Upon admission the resident or resident's representative will be asked to fill out an inventory list of any items with significant value that may be stored at the facility or in a room. [Facility name] will then ask the resident if they wish to have management store any cash or valuables on the inventory list. [Facility name] is not responsible for lost or stolen items or cash in the facility so please do not leave significant sums of cash or valuable items in the rooms". Page 10.

"Section P - Money or Asset Management. We prefer that the resident or a family member of the resident handle any money or any financial decision or pay a resident's bills and a resident has a right to control their own money. However, if this is not possible other arrangements may be made and a fee may be required. [Facility name] will ensure that a resident retains the use and availability of their funds or property unless restrictions are justified and documented, and by signing this contract the resident acknowledges that he or she has been informed of such rights. Furthermore, [facility name] can help with

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{0 970}	Continued From page 25 household budgeting, including paying bills and purchasing goods, but may not otherwise manage a person's property. Staff will provide receipts for, or otherwise document, all transactions. Staff is not allowed to borrow or take possession of resident's funds or property or receive gifts from residents. Again, [facility name] is not liable or responsible for the loss of any cash money or other valuables a resident claim to have lost in the facility". Page 11. On February 6, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee contracts signed by residents and reviewed by the evaluator, were the original contracts containing the waiver of liability language. LALD-A stated new contracts were in draft and had not been executed or provided to the residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed." The evaluator was provided and reviewed a draft copy of the new contract. No further information was provided.	{0 970}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	{01620}		

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{01620}	Continued From page 26	{01620}		

and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to conduct a comprehensive reassessment for one of one resident (R10) with a change in condition.

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

The findings include:

R10 was admitted for services on August 16, 2018.

R10's diagnoses included anoxic brain injury second to heroin, seizure disorder, and myocardial infarction second to heroin.

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{01620}	Continued From page 27	{01620}		

R10's service plan dated March 15, 2022, indicated R10 received services to include medication administration, dressing, grooming, showering, toileting, behavior monitoring, vital sign monitoring, laundry, and housekeeping.

On February 7, 2023, at 12:00 p.m., the evaluator interviewed R10. R10 stated staff were providing care for abdominal and thigh burns received on December 15, 2023, and January 5, 2023. R10 stated the burns were a result of coffee spills and "they are almost healed."

R10's Incident Report dated December 15, 2022, completed by registered nurse (RN)-C at 2:00 p.m., indicated two burns on left abdomen and did not include a burn to left thigh.

R10's assessment dated December 15, 2022, completed by clinical nurse supervisor (CNS)-B at 10:09 a.m., did not address burns. The assessment indicated R10 had a history of attempted suicide and thoughts of suicide and included the intervention of "remove any objects that may be dangerous or potential for self-harm."

R10's Progress notes included the following:
- December 15, 2022, RN-C indicated R10 spilled hot coffee resulting in burns on her left lower abdomen in two areas the "size of silver dollar and the size of a quarter. Skin is peeled but no blistering."

- December 16, 2022, R10 returned from the emergency room with physician orders to change dressing daily and apply Silver Sulfadiazine twice daily to two areas of left abdomen and left thigh.

- December 16, 2022, through December 20, 2022, indicated R10 had refused bandage

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{01620}	Continued From page 28	{01620}		

changes and/or removed bandages daily.

- December 26, 2022, indicated the facility had run out of bandage supplies and were unable to complete bandage changes on December 26, 2022, and December 27, 2022.

- December 29, 2022, indicated bandages had been delivered on December 28, 2022, and wound care "started up at 9:00 p.m. last night."

- January 6, 2023, CNS-B indicated R10 had received new burns to right inner thigh and two to right abdomen. CNS-B had written "RN onsite at 5:30 a.m., January 6, 2023, and immediately assessed resident's burn wounds received the previous evening." Additionally, the progress note written by CNS-B indicated R10 had not reported the new burns to staff, however, an Incident report dated January 5, 2023, at 9:15 p.m., was completed by unlicensed personnel (ULP) and indicated R10 had three new blistered burns.

- January 5, 2023, and January 6, 2023, email conversation between CNS-B and the guardian requesting to unplug stove/oven, remove microwave and remove coffee pot. An email dated January 6, 2023, indicated the guardian had requested the removal of the coffee pot from R10's room.

R10's assessment dated January 6, 2023, completed by CNS-B at 1:01 p.m., did not include an assessment of the burn wounds, however, did address R10's non-compliance with wound dressing changes.

On February 7, 2023, at approximately 11:20 a.m., RN-C stated the nurses suspected R10 may be burning herself "on purpose for attention

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{01620}	Continued From page 29	{01620}		

or something causing self-harm."

On February 7, 2023, at approximately 11:20 a.m., RN-C confirmed a comprehensive assessment had not been conducted with change in condition following the burn incident on December 15, 2022.

The licensee's Initial, and On-Going Nursing Assessment of Residents under the Comprehensive Licensed Agency policy dated August 2021, indicated the RN would review the nursing assessment whenever the resident has returned from a hospital or has a change in condition or experiences an incident.

No further information was provided.

{01640} SS=D — 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to — {01640}

(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,

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{01640}	Continued From page 30	{01640}		

including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R10).

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

The findings include:

R10 was admitted for services on August 16, 2018.

R10's diagnoses included anoxic brain injury second to heroin, seizure disorder, and myocardial infarction second to heroin.

R10's service plan dated March 15, 2022, indicated R10 received services to include medication administration, dressing, grooming, showering, toileting, behavior monitoring, vital sign monitoring, laundry, and housekeeping.

On February 7, 2023, at approximately 12:00 p.m., the evaluator walked with unlicensed personnel (ULP)-E to R10's room and ULP-E

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{01640}	Continued From page 31 stated two ULPs use a Hoyer mechanical lift to transfer R10 and provide daily wound dressing changes. R10's Service Recap summary dated January 2023, indicated staff signed off wound care daily between January 7, 2023, through January 18, 2023. Registered nurse (RN)-C signed off supervision of wound care on January 2, 9, 11, 16, 17, 2023. Clinical nurse supervisor (CNS)-B signed off supervision of wound care on January 13, 18, 2023. R10's Service Plan did not include mechanical transfers or wound care. On February 6, 2023, at 3:06 p.m., Licensed assisted living director (LALD)-A stated service agreements had been updated recently, however, the new service plans that would contain accurate services had not been executed or provided to any residents for signatures. Additionally, LALD-A stated, "this was the week we had planned to get those signed." The evaluator was not provided an updated service plan to include current services. The licensee's Service Plan policy dated December 28, 2022, indicated all residents would have service plans in place based on initial and subsequent assessments, reassessments, monitoring, and individual reviews of the residents needs and preferences. No further information was provided.	{01640}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	{01760}		

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	28209	A. BUILDING: ______ B. WING ______	R 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
{01760}	Continued From page 32	{01760}		

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 interview and record review, the licensee failed to ensure staff administered scheduled medications as ordered for two of two residents (R9, R18).

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:

R9
R9's diagnoses included coronary atherosclerosis and major depressive disorder.

R9's Service Plan dated May 4, 2022, indicated R9 received services to include medication

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{01760}	Continued From page 33	{01760}		

administration.

R7's medication administration summary (MAR) dated January 2023, indicated R9's physician ordered Magnesium 200 milligram (mg) take two (2) tabs by mouth once daily and Senokot S 8.6/50 mg take two (2) tabs twice daily and Vitamin D3 1000 units (U) / mg, take two (2) tabs daily. R9's MAR indicated Magnesium was scheduled at 8:00 a.m. daily. Senokot S was schedule at 9:00 a.m., and 9:00 p.m. daily and Vitamin D3 was scheduled at 9:00 a.m. daily.

R9's January 2023 MAR indicated staff did not administer R9's Magnesium doses as scheduled on the following dates and times:
- 8:00 a.m., January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, 31, 2023 - "skipped - med out of stock, nurse notified."

R9's January 2023 MAR indicated staff did not administer R9's Senokot S doses as scheduled on the following dates and times:
- 9:00 a.m., January 7, 8, 9, 10, 2023 - "skipped - med out of stock, nurse notified."
- 9:00 p.m., January 7, 8, 9, 10, 2023 - "skipped - med out of stock, nurse notified."

R9's January 2023 MAR indicated staff did not administer R9's Vitamin D3 doses as scheduled on the following dates and times:
- 9:00 a.m., January 5,6, 2023 - "skipped - med out of stock, nurse notified."

R18
R18's diagnoses included altered mental status, depression with suicidal ideation, and left sided hemiplegia.

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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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{01760}

Continued From page 34

R18's unsigned Service Plan, dated February 7, 2023, noted services included medication administration assistance six times daily.

R18's January 2023 MAR indicated R18's physician ordered Metamucil 51.7% daily. R18's MAR indicated Metamucil was scheduled at 8:00 a.m., daily.

R18's January 2023 MAR indicated staff did not administer R18's Metamucil doses as scheduled on the following dates and times:
- 8:00 a.m., January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 2023 - "skipped - med out of stock, nurse notified."

On February 7, 2023, at 11:42 a.m., registered nurse (RN)-C confirmed the missed doses for R9 and R18 and stated nursing audited and reviewed declined medications weekly. RN-C stated medication techs were educated to the pharmacy portal and should be ordering medications when they are low or out of stock.

The licensee's Medications and Treatments policy dated December 28, 2022, indicated when ordered or prescribed medications are delegated or assigned to unlicensed personnel (ULP), licensee's registered nurse would communicate with the ULP about the individual needs of the resident.

No further information was provided.

{01890} SS=E

144G.71 Subd. 20 Prescription drugs

A prescription drug, prior to being set up for immediate or later administration, must be kept in

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{01890}	Continued From page 35	{01890}		

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, licensee failed to date time-sensitive medications with an opened-on date for two of two residents (R9, R18).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On February 6, 2023, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated licensee provided medication management services for residents who received services.

On February 6, 2023, at 12:05 p.m., the evaluator reviewed medications in the locked medication cart with unlicensed personnel (ULP)-K.

R9
R9's Novolog insulin pen 100 units (u)/milliliter (ml) lacked labels to indicate the date staff opened the insulin pen and when insulin would expire.

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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

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{01890}	Continued From page 36	{01890}		

The manufacturer's instructions dated January 2019 for the use of the Novolog insulin pen indicated open or in-use pens should be kept at room temperature for a maximum of 28 days. After 28 days, Novolog FlexPen pens should be thrown away in the trash - even if there is leftover insulin.

R18
R18's Levemir Flextouch insulin pen 100 u/ml lacked labels to indicate the date staff opened the insulin pen and when insulin would expire.

The manufacturer's instructions dated March 2018, indicated open or in-use pens should be kept at room temperature for a maximum of 42 days. After 42 days, Levemir FlexTouch pens should be thrown away in the trash, even if there is leftover insulin.

On February 7, 2023, at 2:36 p.m., CNS-B stated all time sensitive medications including the above noted time sensitive medications should be dated after opening with an open date and expiration date.

No further information was provided.

{02040} SS=F — 144G.81 Subdivision 1 Fire protection and physical environment — {02040}

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

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{02040}	Continued From page 37	{02040}		

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 document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment of the physical environment with mitigation factors. This had the potential to directly affect all residents and staff.

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

On February 9, 2023, at approximately 10:00 a.m., documents were provided for review. Documents were reviewed by survey staff on February 9, 2023, between 12:30 p.m. and 1:30 p.m. The hazard vulnerability assessment did not include mitigation factors to protect dementia care residents from harm.

The LALD-(A) confirmed the findings during the exit interview on February 9, 2023, at approximately 1:45 p.m.

No further information was provided.

{02110} SS=F	144G.82 Subd. 3 Policies	{02110}		

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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

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{02110}	Continued From page 38 (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{02110}		

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{02110}	Continued From page 39	{02110}		

licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives for three of three residents (R3, R12, R16).

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:

The facility held a current Assisted Living with Dementia Care license.

On February 6, 2023, at approximately 9:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee was providing dementia care. CNS-B stated the required dementia policies and procedures were located on a thumb drive and available, however, licensee had not provided the new policies to residents and/or the resident's legal and designated representatives.

R3
R3 was admitted for services on June 5, 2019.

R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R12
R12 was admitted for services on March 23,

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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

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{02110}	Continued From page 40 2021. R12's diagnoses included dementia, diabetes, and hypertension (HTN-high blood pressure). R16 R16 was admitted for services on March 23, 2021. R16's diagnoses included dementia, diabetes, and depression. On February 6, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-A stated the dementia policies were a part of the new contract. LALD-A stated the new contract was in draft form and had not been provided to the residents. No further information was provided.	{02110}		
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the residency agreement contract language which limited the rights of five of five residents (R1, R2, R3, R6, R14). This had the potential to affect all residents and visitors. This practice resulted in a level two violation (a	{02290}		

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{02290}	Continued From page 41	{02290}		

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).

Findings include:

R1, R2, R3, R6 and R14's assisted living contract signed and dated respectively, January 17, 2022, May 4, 2022, February 24, 2022, January 31, 2022, and July 22, 2022, included language on pages 18-19 titled House Rules. The House Rules section indicated 12 numbered items that residents were required to follow in order to remain a resident of licensee's facility and included:

- visitors are always welcome at [facility name] 24/7 (except when under state mandated closure or under quarantine rules). Overnight guests will be allowed at the facility to visit only. Overnight guests must be 18 years old or older. Minors must be accompanied by an adult at all times. Guests cannot use [facility name] as a hotel or rest stop. Guests must follow any state or federal laws, and they should follow any terms or rules the resident has agreed to within this agreement. Guests should sign in at the front desk. Guests must pay for any meals or other supplies that they use or consume belonging to [facility name]. Paragraph 1. Page 18.

- there is no drinking of alcoholic beverages. If a resident is believed to have been drinking, the resident agrees under the terms of this contract to take an alcohol detection test and if test is positive medications may be withheld if there are

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{02290}	Continued From page 42 concerns about drug interactions with alcohol. Paragraph 4. Page 18. On February 6, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-A stated the house rules section of the contract had been removed from the new contract. LALD-A stated the new contract was in draft form and had not been provided to the residents. No further information was provided.	{02290}		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Follow-Up
Date: *02/07/23*
Time: 12:45:12
Report: 8046231021

Food and Beverage Establishment Inspection Report

Location:
Birchview Gardens Assisted Liv
108 3rd Street North
Hackensack, MN56452
Cass County, 11

Establishment Info:
ID #: 0038002
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202931472
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

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: 3 comp sink
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: dish contact
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: low boy 3 door
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: reach in cooler 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: reach in cooler 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: reach in 3
Violation Issued: No

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: turkey
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: veggies
Violation Issued: No

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: stuffing
Violation Issued: No

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

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 8046231021 of 02/07/23.

Certified Food Protection Manager:______________________

Certification Number: ______________ Expires: __/ /________

Signed:______________________
Establishment Representative

Signed: Zach Johnson
Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered
December 9, 2022

Administrator
Birchview Gardens Assisted Living, Inc.
108 3rd Street North
Hackensack, MN 56452

RE: Conditional License Number 408796
Health Facility Identification Number (HFID) 28209
Project Number(s) SL28209015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on November 10, 2022, 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, MDH is issuing a 90-day conditional license due to expire on **March 9, 2023**.

Licensing Orders

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 isnot 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts ofeither $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under thischapter for the same circumstance.

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00

St - 0 - 0630 - 144g.42 Subd. 6 (b) - Compliance With Requirements For Reporting Ma - $3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - $3,000.00

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

The total amount you are ass ssed is $12,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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.

The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
b. Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
c. 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 the Department of Health 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 associate 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Requesting a Hearing
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing (but not both) under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order.

CONDITIONAL LICENSE ISSUED:
MDH will issue Birchview Gardens Assisted Living, Inc. 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 Birchview Gardens Assisted Living, Inc. 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:** Birchview Gardens Assisted Living, Inc. will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Birchview Gardens Assisted Living, Inc. must provide the Department:

    i. A list of the names and birthdates of any individuals Birchview Gardens Assisted Living, Inc. 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:** Birchview Gardens Assisted Living, Inc. will contract with an RN to provide consultation concerning all resident(s) to whom Birchview Gardens Assisted Living. Inc. provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Birchview Gardens Assisted Living, Inc. 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 Birchview Gardens Assisted Living, Inc. and MDH must review the RN's credentials and approve the selection. Birchview Gardens Assisted Living, Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Birchview Gardens Assisted Living, Inc. in an effort to help Birchview Gardens Assisted Living, Inc. 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. Birchview Gardens Assisted Living, Inc. 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 Birchview Gardens Assisted Living, Inc. and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

   i. Progress towards correction of licensing 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 the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Birchview Gardens Assisted Living, Inc. to correct the violations cited during the evaluation as well as to determine the overall practice of Birchview Gardens Assisted Living, Inc. 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 Evaluation: At the time of the follow-up evaluation, 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: Birchview Gardens Assisted Living, Inc. 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 Birchview Gardens Assisted Living, Inc. 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 Birchview Gardens Assisted Living, Inc. is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Birchview Gardens Assisted Liv's assisted living facility license, and Birchview Gardens Assisted Living, Inc. will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Birchview Gardens Assisted Living, Inc. is not in substantial compliance, MDH may take additional enforcement action against Birchview Gardens Assisted Living, Inc., 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 (c), 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.

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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	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:
SL28209015-0

On November 7, 2022, through November 10, 2022, 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 39 residents, 38 of whom received services under the provider's Assisted Living with Dementia Care license.

An immediate correction order was identified on November 8, 2022, issued for SL28209015-0, tag identification 2310.

On November 10, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, widespread scope violation.

An immediate correction order was identified on November 9, 2022, issued for SL28209015-0, tag

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.

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0 000	Continued From page 1 identification 1290. On November 10, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread scope violation.	0 000		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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: On November 7, 2022, at 11:52 a.m., licensed assisted living director (LALD)-A stated he was the LALD for the facility.	0 110		

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0 110	Continued From page 2 LALD-A obtained an assisted living director license on July 7, 2021. On November 7, 2022, at 12:54 p.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD-A. The BELTSS website indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was listed as the Director of Record for the licensee. LALD-A stated "they" should have put him down as the director as he only had one site. In addition, he commented he had lost his password. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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	0 250		

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0 250	Continued From page 3 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; (9) interferes with or impedes a representative of 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	0 250		

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0 250		0 250		

Continued From page 4

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) 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 November 7, 2022, at 11:54 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living 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.

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0 250	Continued From page 5	0 250		

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.

- 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.

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0 250	Continued From page 6	0 250		

- 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 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 LALD-A on May 23, 2021.

The licensee had an assisted living license issued on August 1, 2022, with an expiration date of

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0 250	Continued From page 7	0 250		

Continued From page 7

September 30, 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) conducting and handling background studies on employees;
(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
(4) handling complaints regarding staff or services provided by staff;
(5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;
(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;
(7) orientation to and implementation of the assisted living bill of rights;
(8) infection control practices;
(9) medication and treatment management;
(10) delegation of tasks by registered nurses or licensed health professionals; and
(11) supervision of unlicensed personnel performing delegated tasks.

On November 10, 2022, at 3:03 p.m., LALD-A stated he lacked an understanding of 144G statutes for reporting of maltreatment of vulnerable adults, conducting and handling background studies on employees, orientation, training, and competency evaluations of staff, handling complaints regarding staff or services

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0 250	Continued From page 8	0 250		

provided by staff, conducting initial evaluations of residents' needs and the providers' ability to provide those services, 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, infection control practices, medication and treatment management, delegation of tasks by registered nurses, and failed to implement corresponding policies and procedures, as required.

As a result of this survey, the following orders were issued 0110, 0250, 0480, 0485, 0490, 0510, 0550, 0630, 0640, 0680, 0780, 0790, 0800, 0810, 0910, 0920, 0930, 0940, 0950, 0970, 1290, 1460, 1470, 1530, 1550, 1620, 1640, 1730, 1750, 1760, 1770, 1880, 1890, 1940, 1950, 1960, 2040, 2110, 2140, 2290, 2310, 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

0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

(13) offer to provide or make available at least the 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

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0 480	Continued From page 9	0 480		

States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:

(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 had the potential to affect all residents of the assisted living facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 November 8, 2022, for the specific Minnesota Food Code deficiencies.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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0 485	Continued From page 10	0 485		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the 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; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 485		

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The findings include:

During a facility tour on November 7, 2022, at approximately 10:30 a.m., with registered nurse (RN)-C, the surveyor did not observe the menu posted for the day or for the week.

On November 7, 2022, at 10:50 a.m., cook (C)-L stated there was "not enough time" regarding the requirement of posting the menu. Later in the day on November 7, 2022, the surveyor observed the menu was posted for the day, but not for the week.

On November 7, 2022, at approximately 1:30 p.m., registered nurse (RN)-C stated she was not aware of the requirement to have the menu provided to the residents at least a week in advance.

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

0 490 SS=F — 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements — 0 490

(ii) weekly housekeeping;
(iii) weekly laundry service;
(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;
(v) upon the request of the resident, provide

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reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;
(vi) provide culturally sensitive programs; and
(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents who were being provided services at the facility.

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

Findings include:

During the entrance conference on November 7, 2022, at 12:08 p.m., the surveyor asked if the facility had a daily activity calendar. Registered nurse (RN)-C stated the facility provided a daily

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0 490	Continued From page 13 program of social and recreational activities. On November 8, 2022, at 2:26 p.m., unlicensed personnel (ULP)-G stated there were no activities provided today or yesterday afternoon. ULP-G explained she got "pulled" to the medication cart. ULP-G added she was hoping they could get someone tomorrow to do medications. ULP-G said activities were provided every day, but only every other Friday since ULP-G was not schedule to work on those days. On November 9, 2022, at 9:58 a.m., LALD-A stated a staff member had a family matter and had to leave, which effected the activities provided that day. On November 9, 2022, at 10:02 a.m., the surveyor reviewed the posted activity calendar for the month of November with LALD-A. LALD-A confirmed the facility did not offer activities every other Friday. LALD-A added he was not aware of this and was looking at the schedule to change staff around to ensure activities were provided daily. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 14	0 510		

national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.
(c) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP)-D during personal cares.

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 November 9, 2022, at 7:42 a.m., the surveyor observed ULP-D with gloved hands apply compression stockings (TEDs) to R8's legs. ULP-D removed the gloves she had been wearing, applied a new pair of gloves, and positioned a walker near R8. R8 stood up and ULP-D checked the brief R8 was wearing. ULP-D placed a pair of pants over R8's legs, partially pulling the pants up R8's legs. ULP-D removed gloves and applied new gloves. ULP-D went to the sink in the bathroom to get a washcloth and a dry hand towel. ULP-D removed the brief R8 had

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on and placed the brief into a trash bag. There was some light soiling in the brief, and it appeared to be wet. ULP-D cleaned R8's perineal area with the washcloth. ULP-D went to the sink to rinse the washcloth in a basin and then returned to complete R8's perineal care and dried the area with the hand towel. ULP-D removed gloves, and pulled R8's new brief and pants up. ULP-D assisted R8 into a wheelchair and applied R8's shoes. ULP-D brushed R8's hair, applied body spray, and washed and dried R8's glasses and handed them to R8. ULP-D rinsed out the basin used, made R8's bed, gathered R8's trash and left R8's room with trash in hand. ULP-D did not complete hand hygiene at any point during the surveyor's observation.

Directly following the observation, on November 9, 2022, at 7:49 a.m., ULP-D stated, "there are not sinks everywhere, I don't wash hands in room", adding "they" [facility] don't make us carry pocket sanitizers."

On November 9, 2022, at 2:26 p.m., clinical nurse supervisor (CNS)-B stated hands should be washed, "or at the minimum sanitizer used in between glove changes." CNS-B added there are not sinks on every floor.

The licensee's Procedure For Using Gloves policy dated August 1, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressing. Gloves will be removed carefully and disposed of in a proper container:
- wash hands;
- apply gloves to both hands;
- complete task. If gloves become torn or heavily

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0 510	Continued From page 16 soiled and additional tasks must be performed for the client [resident], then change the gloves (washing hands before putting on new gloves before starting the next task); - place any contaminated material in proper receptacles-such as biohazardous waste for wound care dressing; - remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove; - dispose of used gloves in proper receptacle-biohazardous if they have contaminated material on them; and - rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced	0 550		

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0 550	Continued From page 17 by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2022, at approximately 11:00 a.m., the surveyor toured the facility with registered nurse (RN)-C. The licensee had a bulletin board on the first floor which contained miscellaneous postings, however, lacked the grievance procedure posting with information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On November 7, 2022, at approximately 11:20 a.m., RN-C verified licensee lacked the required posting. RN-C stated she was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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(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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of four residents (R10, R1, R3).

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:

R10, R1, and R3's records lacked an individual abuse prevention plan which reviewed each resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; the resident's risk for self-abuse; and statements

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of the specific measures to be taken to minimize the risk of abuse to that resident and other vulnerable adults.

R10
R10's diagnoses included anoxic brain injury secondary to heroin use, seizure disorder, encephalopathy prolonged, and myocardial infarction secondary to heroin use.

R10's Service Plan dated March 15, 2022, indicated services included bathing, dressing, grooming, transfers, toileting, behavior monitoring, and medication assistance.

On November 8, 2022, at approximately 2:45 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R10 with toileting.

R10's IAPP dated August 12, 2021, updated February 9, 2022, May 10, 2022, August 2, 2022, and October 29, 2022, indicated R10 was at risk for falls, was wheelchair bound, required assistance from two staff with a Hoyer lift (a mechanical assistive device) for turning/repositioning/sitting up and all transfers. R10 needed occasional help with wheelchair ambulation, had a history of alcohol and substance abuse and "pocketing" medications in cheeks. A behavior category within the IAPP indicated R10 could be verbally abusive to staff with threats and use of foul language and a safety category within the IAPP indicated R10 would need assistance in an emergency due to physical limitations and comprehension difficulties.

ASSESSMENT OF R10's SUSCEPTIBILITY TO ABUSE BY ANOTHER INDIVIDUAL

R10's IAPP dated August 12, 2021, updated

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February 9, 2022, May 10, 2022, August 2, 2022, and October 29, 2022, indicated R10 was at risk to be abused and indicated the measures in place to minimize the risk were as follows:
- R10 had a call pendant;
- staff had background checks; and
- licensee conducted annual training for staff pertaining to vulnerable adults.

R10's IAPP did not change to include evaluations of interventions or measures put in place from August 12, 2021, to October 29, 2022. On August 12, 2021, registered nurse (RN)-J added a note to R10's assessment, but did not include a date of occurrence, "said was going out for a smoke and wheeled self in the winter to local hotel to meet male friend. Was found by police intoxicated and naked in bed in motel room, was transported to the ED."

R10's record included the following progress notes entered by staff:
- May 20, 2022, R10 left the facility without telling staff or signing out and was later wheeled back to the facility by a community member and was "shaking extremely bad."
- May 25, 2022, R10's guardian filed a "notice of restriction" with the courts and R10 was not allowed to leave [facility name] without permission from management or guardian. The document noted if R10 left without consent, R10 was leaving against advice of [facility name] and R10 was liable for any incidents that may occur while out, staff would not be responsible to go get her in the event she was unable to return on her own.
- May 30, 2022, "[R10] paged, staff stepped outside and she [R10] was sitting in the middle of the parking lot. She stated she needed help getting back inside. Writer told [R10] she got outside by herself to smoke and she needed to

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0 630	Continued From page 21 get herself back in." - June 9, 2022, "resident went outside for a smoke and paged from just outside the door jumping like crazy in her chair. Sock was half off and shoe was lying about 1.5 feet away. She [R10] claimed she couldn't get back in." - June 22, 2022, "resident was told to calm down before she ate her meal, when writer went back in there, resident informed writer she had a "seizure" and threw her food all over. I told her that I hope she picked it all up good so she doesn't get mice. She said she didn't." - June 28, 2022, "at 12 a.m. neuro checks, resident was in smoke room, claims her fingers weren't working good enough to put hearing aides in and she needed writer to do, so I told her then they probably didn't work well enough to smoke so she [R10] left the smoke room. A few minutes later she paged phone was on floor in hall battery popped out, grabber on floor. I told her she needs to go back to her room. I picked up her stuff, pushed her to her room and told her she needs to stay in her room if she can't transport herself to and from places." - July 12, 2022, R10 left the facility at 4:00 p.m., with the guardian's permission to attend a parade. The noted indicated a request by clinical nurse supervisor (CNS)-B to document the return time of R10. - July 14, 2022, indicated a late entry by registered nurse (RN)-C, "resident returned from parade not sure the time on Tuesday, July 12. Staff reported that resident was flopping like a jelly fish in her wheelchair. Staff also reported that resident seemed like she was high on something, not sure what." - July 31, 2022, "writer got phone call just before 7:00 p.m. from [RN-C], she saw several residents on 371 (main highway), resident [R10] being one of them. Was told to go get her, it was raining so I	0 630		

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took my car. Writer spotted [R13 and R17] first, then further down the road I saw resident [R10]. I pulled up to her and asked if she had permission to leave and she said no, then I told her she needed to come back to the building. I followed her back. I reminded her she can't leave without telling someone, and she now has to have permission from [licensed assisted living director name] and or [guardian name].
- September 5, 2022, " resident went outside to smoke a little bit ago, paged around 1:30 a.m., found outside between first set of first set of doors. I told her if she can't get herself back in than she can't go out no more, she calmed down almost instantly."

ASSESSMENT OF R10's SELF-ABUSE

Additionally, R10's IAPP's did not change to include evaluations of interventions or to specify measures for staff to manage R10's history of suicidal ideology or suicide attempts from August 12, 2021, to October 29, 2022. On August 12, 2021, RN-J entered the following information into R10's IAPP:
- "has a history of suicide attempt with a transfer belt. Went to off sale and got drunk - fell off the curb, face planted and had to go to ER. Does not make wise choices. Leaves facility in wheelchair does not let staff know where she is going, went to local hotel with ex-boyfriend, was found by police with bottles of alcohol in the hotel room and had to be taken to the ER due to intoxication and unknown other substances."

ASSESSMENT OF R10's RISK OF ABUSING OTHER VULNERABLE ADULTS

R10's IAPP dated August 12, 2021, updated February 9, 2022, May 10, 2022, August 2, 2022,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and October 29, 2022, indicated R10 had not been assessed for the risk of abuse to other vulnerable adults; and did not include statements of the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. R10's IAPP's included the same vulnerability information from August 12, 2021, to October 29, 2022, with one additional piece of information added on May 10, 2022, that R10 had struck out against staff and attempted to choke a caregiver months earlier with a police report filed.
R10's record included the following information:
- incident report dated February 8, 2022, indicated R10 had aggressive behavior and physically assaulted a staff member. Licensed assisted living director (LALD)-A, CNS-B, RN-C and the sheriff's department were notified at the time of the incident and charges filed against R10.
- progress note dated June 9, 2022, indicated staff were assisting R10 with a mechanical lift transfer and R10 "threw a slipper at [staff name] and made a comment to staff they were lucky it was not a shoe. Trying to get out of there quickly, resident [R10] handed a steak knife to [staff name] smiling wickedly, scared crap out of me."
- progress note dated June 27, 2022, indicated "during third set of vitals resident [R10] started kicking me, I moved to her side and she swung her arm out hitting me, after each time she says she's sorry."
- progress note dated September 1, 2022, indicated, "writer and [staff name] went to check clear residents page. Resident stated she had a mess in her bathroom by the sink. Resident had spilled various items including a steak knife on the floor/in the sink. Writer confiscated the steak knife."

R1

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Continued From page 24

R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, anemia, chronic kidney disease, congested heart failure, hyperglycemia, and mood disorder.

R1's Service Plan dated March 14, 2022, noted services included dressing, incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully, measuring how much air you can breathe into your lungs), oxygen checks, blood glucose monitoring daily, vital sign monitoring, medication assistance, shower assistance, perineal care, and housekeeping.

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen), lying in bed while ULP-G administered R1's morning medication.

R1's IAPP dated October 7, 2022, indicated R1 required full help with bathing and dressing, full help with grooming, some help with meal setup, full help with grooming/hygiene, help to be turned and repositioned and some help to sit up in bed, help with medication management, assistance with oxygen, shopping services, help in arranging transportation, assistance with hearing aids, required help in emergency, was not able to evacuate without help due to anxiety, and was unable to activate emergency call system in an emergency situation.

R1's IAPP lacked a review of R1's susceptibility to abuse by another individual, including other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to R1.

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R3
R3's diagnoses included acute ischemic heart disease, vascular dementia, and peripheral artery disease.

R3's Service Plan dated March 21, 2022, indicated R3 required medication management, dressing, toileting, skin treatment, additional personal living assistance, laundry, and housekeeping.

R3's Individual Abuse Prevention Plan, dated May 18, 2022, indicated R3 was at risk for falls, required full medication management, used hearing amplifiers and a communication whiteboard due to inability to speak or communicate. R3 required help in emergencies due to physical limitations, comprehension difficulties, and R3's mental status was difficult to assess due to aphasia (inability to comprehend or formulate language). The IAPP referred reader to "See abuse prevention care plan" as a response to whether R3 was susceptible to abuse by another individual, including other vulnerable adults; and did not include statements of specific measures to be taken to minimize the risk of abuse to R3.

On November 9, 2022, at 12:49 p.m., RN-J stated IAPP's are completed with each assessment, however, she was unaware of the exact information that needed to be entered due to being a new user to the electronic records system. LALD-A stated R10 is "very complex", and the licensee had been searching for appropriate placement in coordination with R10's guardian for "about a year and a half, over 50 referrals. They read her information and deny her acceptance. We are an open facility, and they

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0 630	Continued From page 26 can come and go as they want." The licensee's Initial and On-Going Nursing Assessment of Residents policy, updated and signed February 5, 2022, by RN-J, indicated an assessment would be completed for all residents assessing the residents areas of vulnerability and susceptibility to maltreatment and whether the resident posed a risk to other vulnerable adults. The assessment would provide the basis for the residents IAPP identifying specific measures to be taken to minimize the risk of maltreatment to the resident or to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 640		

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0 640	Continued From page 27 failed to post the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2022, at 2:10 p.m., the surveyor toured the main entry/open common's area with licensed assisted living director (LALD)-A. The surveyor did not observe the required posting information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On November 7, 2022, at 2: 12 p.m., LALD-A stated the contact information for MAARC was not posted as required adding that information was in the packet the facility gives to prospective residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 28 (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 tenant 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 with all the required content and failed to prominently post an emergency disaster plan. This had the potential to affect all residents receiving services under the assisted living with dementia care license, 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	0 680		

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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 November 7, 2022, at approximately 11:00 a.m., the surveyor toured the facility and observed a stapled set of seven emergency plan documents tacked to a corkboard. On November 7, 2022, at approximately 11:45 a.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The emergency plan provided was the same set of documents that were tacked to the corkboard.

The licensee's emergency preparedness plan included emergency plans for fire, heat/humidity, severe weather, water shortage, bomb threat, winter storms, and a template for Appendix Z that was incomplete.

The licensee's plan lacked the following content and/or policies and procedures to address:
- a description of the population served by the licensee;
- process for emergency preparedness (EP) cooperation with state and local EP officials/organizations;
- the facility's role in providing care and treatment at alternative sites;
- the provision of subsistence needs for staff and residents;
- a tracking system used to document locations of residents and staff;
- an evacuation plan;

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- how the facility would provide a means to shelter in place for residents and volunteers;
- the medical record documentation system the facility has developed to preserve resident information security and availability of records;
- EP training and testing program;
- EP training program for staff (including documentation of training provided); and
- EP testing/annual testing requirements.

In addition, the licensee lacked a communication plan that included:
- names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers;
- contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies;
- a method of sharing information and medical documentation for residents;
- a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and
- a method of sharing information from the emergency plan with residents and their families.

On November 8, 2022, at approximately 2:45 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. LALD-A stated he was unsure of what all was required and thought the current plan/policy covered the emergency preparedness requirements.

The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility would have in place an effective and compliant emergency preparedness plan. The intent of the

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0 680	Continued From page 31 plan would be aligned with the Centers for Medicare and Medicaid state operations manual Appendix Z - emergency preparedness. The emergency preparedness plan would include all required elements of Appendix Z, would be in writing and reviewed annually. 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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This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff.

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

On November 8, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that when smoke alarms in resident apartment 4 were tested by the LALD-A, none of the other alarms within the dwelling unit were activated. During the facility tour interview, the LALD-A confirmed that smoke alarms were not interconnected in apartment 4 so that actuation of one alarm caused all alarms in the dwelling unit to operate.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

(2) install and maintain portable fire extinguishers in accordance with the State Fire

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0 790	Continued From page 33	0 790		

Code;

(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This had the potential to directly affect all residents and staff.

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

On November 8, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following:
1. The service tag on a portable fire extinguisher in the basement was dated April 2021.
2. The service tag on the portable fire extinguisher in the beauty shop was dated 2017.

During the facility tour, the LALD-A confirmed that portable fire extinguisher maintenance was required to be completed annually by a service

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0 790 | 0 790

Continued From page 34

company.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

0 800 SS=F | 0 800

144G.45 Subd. 2 (a) (4) Fire protection and physical environment

(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.

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

On November 8, 2022, between 10:30 a.m. and 12:45 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During

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0 800	Continued From page 35 the facility tour, survey staff observed the following: 1. The ceiling in the lower-level swimming pool had not been maintained and had been removed. Based on the fire sprinkler head placement, a ceiling assembly is required to be in place and to be maintained for the automatic sprinkler system to work in a timely and effective manner as designed. On November 8, 2022, at approximately 2:30 p.m., during an interview with the LALD-A, they stated that the pool room fire sprinklers had not been evaluated since the ceiling was removed and visually verified this deficient condition at the time of finding. 2. Burnt used cigarettes were observed being disposed of in a garbage can with a plastic liner outside of the smoking room in an adjacent storage room instead of in the listed disposal container provided in the smoking room. During the facility tour interview, LALD-A verified that the used cigarettes had not been disposed of properly. 3. The door closer was disconnected on the smoking room door. 4. Above the shower in resident apartment 4, the ceiling was damaged and the surface peeling. Additionally, one piece of cove base was missing in this bathroom near the shower. 5. The cap for the storm water connection was broken on the ground in front of the building. During the facility tour interview, the LALD-A confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 36	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: Based on document review and interview, the licensee failed to provide the required training and	0 810		

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	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 810	Continued From page 37 drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 8, 2022, at approximately 12:45 p.m., documents were provided for review. Documents were reviewed by survey staff on November 8, 2022, between 12:45 p.m. and 2:30 p.m. 1. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. 2. Completed fire drill logs were provided. Evacuation drills were not completed between 10-12-2021 and 05-13-2022. The licensee did not meet the evacuation drill frequency requirements during this time. The LALD-(A) confirmed the findings during the exit interview on November 8, 2022, at approximately 2:30 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 910	Continued From page 38	0 910		

Continued From page 38

(a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility.
(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:
(1) the facility and contracted service provider when applicable;
(2) the licensee of the facility;
(3) the managing agent of the facility, if applicable; and
(4) the authorized agent for the facility.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ___ B. WING ___	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
0 910	Continued From page 39 2021, was signed by R3's power of attorney on February 24, 2022. R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022. R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022. R1, R2, R3, R6, and R10's assisted living contracts lacked the following required content: - the HFID number (provider identification number); - the managing agent of the facility, if applicable; and - the authorized agent for the facility. On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ___ B. WING ___	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 920	Continued From page 40 the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10). 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: R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
0 920	Continued From page 41	0 920		

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022.

R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022.

R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022.

R1, R2, R3, R6, and R10's assisted living contracts lacked the following required content:
- disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and
- disclosure of the facility's ability to provide specialized diets.

On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
0 930	Continued From page 42	0 930		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information	0 930		

(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.
(e) The contract must include a clear and conspicuous notice of:
(1) the right under section 144G.54 to appeal the termination of an assisted living contract;
(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;
(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;
(4) the resident's right to obtain services from an unaffiliated service provider;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 930	Continued From page 43 The findings include: R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022. R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022. R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022. R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022. R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022. R1, R2, R3, R6 and R10's assisted living contracts lacked: - the name and contact information of the person representing the facility who is designated to handle and resolve complaints; - the right under section 144G.54 to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward.	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 930	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 940	Continued From page 45	0 940		

(6) the contact information to obtain long-term care consulting services under section 256B.0911; and
(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for five of five residents (R1, R2, R3, R6, R10).

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022.

R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022.

R10's Assisted Living Contract effective August 1,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
0 940	Continued From page 46	0 940		

2021, was signed by R10's guardian July 15, 2022.

R1, R2, R3, R6, and R10's Assisted Living Contracts all lacked disclosure of:
- a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including;
- whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;
- whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);
- whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;
- a statement that medical assistance waivers provide payment for services but do not cover the cost of rent;
- a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and
- the toll-free number for the Minnesota Adult Abuse Reporting Center (MAARC).

On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
0 940	Continued From page 47 (21) days	0 940		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity	0 950		

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0 950	Continued From page 48	0 950		

to identify a designated representative in writing with the required statutory language for five of five residents (R1, R2, R3, R6, R10) with records reviewed.

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:

R1's Assisted Living Contract effective August 1, 2021, was signed by the resident January 17, 2022.

R2's Assisted Living Contract effective August 1, 2021, was signed by the resident May 4, 2022.

R3's Assisted Living Contract effective August 1, 2021, was signed by R3's power of attorney on February 24, 2022.

R6's Assisted Living Contract effective August 1, 2021, was signed by the resident January 31, 2022.

R10's Assisted Living Contract effective August 1, 2021, was signed by R10's guardian July 15, 2022.

R1, R2, R3, R6 and R10's Elderly Housing with Services Contract lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice.

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0 950	Continued From page 49 On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living agreement did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 970	Continued From page 50	0 970		

or has potential to affect a large portion or all of the residents).

The findings include:

R1, R2, R3, R6, and R10's Assisted Living Contracts dated January 17, 2022, May 4, 2022, February 24, 2022, January 31, 2022, and July 15, 2022, respectively, contained two paragraph clauses indicating the resident would waive the facility's liability as follows:

"Section N - Personal Property. Upon admission the resident or resident's representative will be asked to fill out an inventory list of any items with significant value that may be stored at the facility or in a room. [Facility name] will then ask the resident if they wish to have management store any cash or valuables on the inventory list. [Facility name] is not responsible for lost or stolen items or cash in the facility so please do not leave significant sums of cash or valuable items in the rooms". Page 10.

"Section P - Money or Asset Management. We prefer that the resident or a family member of the resident handle any money or any financial decision or pay a resident's bills and a resident has a right to control their own money. However, if this is not possible other arrangements may be made and a fee may be required. [Facility name] will ensure that a resident retains the use and availability of their funds or property unless restrictions are justified and documented, and by signing this contract the resident acknowledges that he or she has been informed of such rights. Furthermore, [facility name] can help with household budgeting, including paying bills and purchasing goods, but may not otherwise manage a person's property. Staff will provide

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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

(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
0 970	Continued From page 51 receipts for, or otherwise document, all transactions. Staff is not allowed to borrow or take possession of resident's funds or property or receive gifts from residents. Again, [facility name] is not liable or responsible for the loss of any cash money or other valuables a resident claim to have lost in the facility". Page 11. On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract was the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290		

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01290	Continued From page 52 by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care license for two of four employees (unlicensed personnel ULP-G, ULP-H.) 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 order for correction on November 9, 2022. The findings include: ULP-G ULP-G was hired on January 10, 2019, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021. ULP-G's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated January 9, 2019. On November 8, 2022, at 8:06 a.m., the surveyor observed ULP-G administer morning medications to R1. ULP-H	01290	On November 10, 2022, the immediacy of correction order 1290 was removed, however, non-compliance remained at a level 3, widespread scope violation.	

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01290	Continued From page 53	01290		

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ULP-H was hired on September 12, 2011, under the licensee's former comprehensive home care license and began providing assisted living services to the licensee's residents on August 1, 2021.

ULP-H's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license, dated May 4, 2016.

ULP-G and ULP-H's employee records lacked evidence of cleared background studies, affiliated with the licensee's current assisted living with dementia care license, effective August 1, 2021.

On November 9, 2022, at 8:44 a.m., registered nurse (RN)-J stated she does "nothing with background studies," adding resident services (RS)-I and scheduler (S)-F were responsible for the background studies.

On November 9, 2022, at 8:46 a.m., S-F stated RS-I submits information for background studies, and "I" [S-F] file the background studies.

The licensee's undated Screening of Home Care Job Applicants policy indicated all job applicants would be screened to assure compliance with applicable state laws and our agency's requirements, including background checks.

On November 9, 2022, at approximately 9:10 a.m., the surveyor verified through Department of Human Services NetStudy 2.0 the following:
- There was no cleared background study or pending application in NetStudy 2.0 for ULP-G or ULP-H under the licensee's name or license number.

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01290	Continued From page 54 On November 9, 2022, at 9:25 a.m., the surveyor informed LALD-A of the immediate correction order for lack of affiliated background studies for employees ULP-G and ULP-H, and that the employees either needed to be immediately removed from the schedule or be closely supervised by an employee with a cleared background study. The surveyor informed LALD-A this would need to be the case until ULP-G and ULP-H's background studies were cleared and affiliated with the licensee's current license. LALD-A stated they called RS-I and spoke to her about current background studies, and he set up a new account with the new number and RS-I told him she processed them. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of one employee (clinical	01460		

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01460	Continued From page 55	01460		

nurse supervisor (CNS)-B).

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 the potential to affect a large portion or all of the residents).

The findings include:

CNS-B's employee record did not contain documentation that the licensee oriented CNS-B to assisted living licensing requirements.

CNS-B began employment on October 12, 2018, under the comprehensive home care license and began providing direct care and supervisory services under the assisted living services license on August 1, 2021.

On November 9, 2022, at 12:08 p.m., CNS-B stated, "I did whatever was assigned to me. We used to use discs, but that isn't documented anywhere."

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470		

(a) The orientation must contain the following topics:

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01470	Continued From page 56 (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 (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:	01470		

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(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 orientation to assisted living statutes including required content was completed for two of three employees (unlicensed personnel (ULP)- D, ULP-G) with records reviewed.

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 the potential to affect a large portion or all of the residents).
The findings include:
ULP-D
ULP- D was hired on April 10, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On November 8, 2022, at 7:42 a.m., the surveyor

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observed ULP-D apply compression stockings to R8's legs.

ULP-D's employee record lacked the following required orientation content:
- an overview of the 144G statutes;
- handing of resident complaints, reporting of complaints, where to report;
- consumer advocacy services;
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and
- the principles of person-centered planning and services delivery and how they apply to direct support services provided by the staff person.

ULP-G
ULP-G was hired on January 10, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On November 8, 2022, at 8:06 a.m., the surveyor observed ULP-G administer R1's morning medication.

ULP-G's employee record lacked the following required orientation content:
- an overview of the 144G statutes;
- handing of resident complaints, reporting of complaints, where to report;
- consumer advocacy services;
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and
- the principles of person-centered planning and services delivery and how they apply to direct support services provided by the staff person.

On November 9, 2022, at 12:08 p.m., the

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surveyor reviewed ULP-D and ULP-G's employee records with scheduler/manager (SM)-F. SM-F stated ULP-D, ULP-G and other staff "older hires" would be missing at least some of the training.

The licensee's Home Care Orientation policy dated August 1, 2021, indicated all comprehensive home care [policy referred to license type formerly held by licensee] employees, including those who provide direct care, who provide supervision of direct care, or who provide management services, must complete their orientation to home care requirements before providing home care services to clients. Various materials, including materials prepared by MDH (Minnesota Department of Health), may be used to orient employees to home care. At minimum, this orientation must include the following topics: and overview of Minnesota's home car law, an introduction and review of all of our agency's policies and procedures related to the provision of home care services, handing emergencies and use of emergency services, reporting the maltreatment of vulnerable minors or adults under Minnesota Statues, the home care bill of rights, and our program's system for receiving and responding to complaints, where to report complaints, and information on the Office of Health Facility Complaints and the Common Entry Point and how clients, staff and others may contact these agencies with complaints.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days

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01530	Continued From page 60	01530		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of four employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-E) received the required amount of dementia care training, in the required time frame and failed to ensure they received the required two hours of annual dementia training.	01530		

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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:

The licensee provided services under an assisted living with dementia care license.

During an interview with CNS-B on November 7, 2022, at approximately 10:30 a.m., CNS-B stated the licensee provided services to residents with dementia and other related disorders.

CNS-B
CNS-B began employment on October 12, 2018, under the comprehensive home care license and began providing direct care and supervisory services under the assisted living with dementia care license on August 1, 2021.

On November 9, 2022, throughout the day, the surveyor observed CNS-B interact with and provide instruction to licensee's staff and provide assistance to licensee's residents.

CNS-B's record included an Educare (electronic training system) transcript, indicating CNS-B had completed 2 hours of training in dementia care as of November 9, 2022, therefore, less than the required 8 hours within 120 working hours. Additionally, CNS-B's record did not contain the

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required 2 hours of annual dementia training.

ULP-E
ULP-E started employment on November 8, 2021.

On November 8, 2022, at 9:18 a.m., the surveyor observed ULP-E assist R10 with repositioning and assist with a bedpan.

ULP-E's record included an Educare training transcript, indicating ULP-E had completed 3.25 hours of training in dementia care as of November 9, 2022, therefore less than the required 8 hours within 160 working hours. Additionally, ULP-E's record did not contain the required 2 hours of annual dementia training.

On November 9, 2022, at 10:37 a.m., scheduler/manager (SM)-F confirmed the employees lacked the required amount of initial training in dementia care and stated, "I have taken over the training recently, we will get that assigned to all staff."

The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff were required to complete dementia training at the time of hire and annually thereafter, and identified non-direct care staff would complete four hours of initial training within 160 hours of the employment start date.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-One (21) days

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01550	Continued From page 63	01550		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	01550		

(4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for one of three employees (cook assistant (CA)-M). In addition, the licensee failed to ensure CA-M received two hours of annual dementia training.

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 an interview with clinical nurse supervisor (CNS)-B on November 7, 2022, at approximately 10:30 a.m., CNS-B stated the licensee provided services to residents with dementia and other

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01550	Continued From page 64 related disorders. CA-M started employment on October 13, 2021. CA-M's employee record lacked evidence CA-M completed the required four hours of dementia training within 160 working hours of CA-M's hire date and lacked evidence CA-M completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On November 9, 2022, at 2:06 p.m., scheduler/manager (SM)- F confirmed CM-M had worked 160 hours prior to November 7, 2022. On November 9, 2022, at approximately 4:00 p.m., the surveyor observed CA-M working in the dining room of the facility. On November 9, 2022, at 11:39 a.m., scheduler/manager (SM)- F confirmed CA-M was lacking the required initial dementia training. SM-F added "I am really cracking down." The licensee's Dementia Training policy, dated August 1, 2021, indicated all staff were required to complete dementia training at the time of hire and annually thereafter, and identified non-direct care staff would complete four hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current smoking status for four of four residents (R8, R3, R10, R2). Additionally, the licensee failed to conduct a comprehensive reassessment for one of five residents (R1) with a change in condition.

This practice resulted in a level two violation (a violation that did not harm a resident's health or

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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:

SMOKING ASSESSMENT

R8
R8's diagnoses included diabetes, anxiety, atrial fibrillation, major depressive disorder, gastroesophageal reflux disease, heart failure, insomnia, and cognitive impairment.

R8 Service Plan dated March 14, 2022, indicated R8 received services to include dressing assistance, behavior monitoring, cpap cleaning (continuous positive airway pressure therapy is a common treatment for obstructive sleep apnea), medication assistance, vital sign monitoring, skin care, transfer assistance, toileting assistance and compression stockings assistance, housekeeping, and laundry.

R8's Assessment dated August 16,2022, included a section titled "Safe Smoking". This section indicated smoking assessment was not applicable.

On November 8, 2022, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-D apply compression stockings to R8's legs and assist R8 with morning cares. ULP-D then freshened R8's bed. While remaking R8's bed the surveyor observed an empty package of cigarettes in R8's folded bedspread.

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On November 9, 2022, at approximately 8:30 a.m., ULP- K stated R8 had smoked for "a while."

On November 9, 2022, at 8:59 a.m., R8 stated he quit smoking for about a year, but had been smoking for "a while now." R8 joked with scheduler/manager (SM)-F and said, "she is trying to get me to quit."

On November 9, 2022, at 12:59 p.m., clinical nurse supervisor (CNS)-B stated she was not aware R8 was smoking and CNS-B stated a smoking assessment had not been completed "yet".

R3
R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R3's service plan dated March 21, 2022, indicated R3 received services to include medication administration, dressing, showering, toileting, skin treatment, vital sign monitoring, laundry, and housekeeping.

R3's Assessment dated May 11, 2022, included a section titled "Safe Smoking". The section indicated R3 was a heavy smoker, more than a pack a day and was safe to smoke independently without interventions.

R3's Individual Abuse Prevention Plan (IAPP) dated August 11, 2022, indicated R3 would need help in an emergency due to physical limitations and comprehension difficulties. R3 was unable to communicate without the use of a whiteboard due to aphasia (inability to comprehend or formulate language) and required hearing amplifiers. The general safety section of the assessment

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indicated R3 was unable to activate an emergency call system and had been known to wander the community looking for cigarettes.

R3's assessment did not identify whether R3 was able to safely manage holding a cigarette, lighting a cigarette, extinguish a cigarette or securely and safely manage the flammable resource to light the cigarettes.

On November 9, 2022, at 7:35 a.m., the surveyor observed a full-size cigarette that had previously been lit sitting on a corner of the printer located in a cubby type room off the main entry lounge area. The surveyor asked ULP-E who the cigarette belonged to, and ULP-E stated, "that's probably [R3's name], he likes to stash his cigarettes around." ULP-E stated R3 "goes into the basement in the smoke room or outside by himself when he wants to smoke."

R10
R10's diagnoses included anoxic brain injury second to heroin, seizure disorder and myocardial infarction second to heroin.

R10's service plan dated March 15, 2022, indicated R10 received services to include medication administration, dressing, grooming, showering, behavior monitoring, toileting, vital sign monitoring, laundry, and housekeeping.

R10's Assessment dated October 29, 2022, included a section titled General Safety. The section indicated R10 goes to the basement smoke room or outside to smoke, was able to smoke safely on her own without interventions and smoked 1-2 cigarettes a day.

R10's progress notes indicated as recently as

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September 5, 2022, at 1:39 a.m., R10 was unable to safely return to the inside of the facility by herself after having gone outside to smoke.

R10's IAPP dated October 29, 2022, indicated R10 needed an assistance of two staff for all transfers, sitting up or repositioning in bed and was wheelchair bound. R10 had seizure precautions and would need help in an emergency due to physical limitations and comprehension difficulties.

R10's assessment did not identify whether R10 was able to safely manage holding a cigarette, lighting a cigarette, extinguish a cigarette or securely and safely manage the flammable resource to light the cigarettes.

R2
R2's diagnoses included tobacco use disorder, cognitive impairment, back disorder, chronic kidney disease, and diabetes

R2's Service Plan dated May 4, 2022, indicated R2 received services to include morning dressing and grooming, assistance to dining room, medication assistance, shower assistance, vital sign monitoring, and daily reminders.

R2's Assessment dated May 11, 2022, included a section titled "Safe Smoking". The section indicated R2 was able to smoke safely.

R2's Assessment did not identify if R2 was able to smoke independently, without intervention. In addition, R2's assessment did not identify whether R2 was able to safely manage holding a cigarette, lighting a cigarette, extinguish a cigarette or securely and safely manage the flammable resource to light the cigarettes.

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On November 8, 2022, at 7:45 a.m., CNS-B confirmed R8, R3, R10 and R2 lacked a smoking assessment that contained all required content and stated, "Those are the assessments, I didn't know there was supposed to be a separate smoking assessment." On November 8, 2022, at approximately 9:00 a.m., RN-C stated all residents that smoke maintain and manage their own matches or lighters for smoking.

CHANGE OF CONDITION ASSESSMENT

R1
R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, anemia, chronic kidney disease, congested heart failure, hyperglycemia, and mood disorder.

R1's Service Plan, dated March 14, 2022, noted services to include morning dressing, incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully, measuring how much air you can breathe into your lungs), oxygen checks, blood glucose monitoring daily, vital sign monitoring, medication assistance, shower assistance, perineal care, and housekeeping.

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen) lying in bed. ULP-G assisted R1 to a seated position to administer R1's morning medications.

On November 8, 2022, at 9:13 a.m., the surveyor and CNS-B reviewed R1's service plan, prescriber's orders, and medication

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01620	Continued From page 71 administration record. CNS-B stated R1's services and oxygen administration changed after he was "sent in" to the emergency department. CNS-B stated R1 was "not himself", had an" increase in confusion", and was "picking at scab on his arms." CNS-B confirmed a change of condition assessment was required but was not completed, "missing that one [change of condition assessment]." The licensee's Initial and On-Going Nursing Assessment policy dated February 5, 2022, indicated the initial nursing assessment would be conducted for resident's functional status and focused assessment for any area of concern identified. The RN would reassess the resident and update the assessment if the resident had a change in condition or experienced an incident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	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	01640		

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and how to contact the Office of Ombudsman for Long-Term Care.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for four of four residents (R12, R1, R3, 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) 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:

R12
R12 was admitted for services on March 23, 2021.

R12's diagnoses included diabetes, hypertension, dementia, and mood disorder.

R12's Service Plan dated March 14, 2022, noted services to include medication assistance five

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times per day.

On November 7, 2022, during a review of the medication cart the surveyor observed six prefilled syringes of hydromorphone (used for moderate to serve pain) 1 milligram(mg)/1 milliliter (ml) and 12 prefilled syringes of 0.25 mg/ 0.5 ml Ativan (used for anxiety) for R12 set up by facility nursing staff.

On November 7, 2022, at 3:46 p.m., registered nurse (RN)-C stated R12's Service Plan had not been updated to reflect the current services being provided. R12's service plan did not include medication set up, only medication assistance.

R1
R1 was admitted for services on May 4, 2020.

R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, anemia, chronic kidney disease, congested heart failure, hyperglycemia, and mood disorder.

R1's Service Plan, dated March 14, 2022, noted services to include medication assistance nine times daily, morning dressing, incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully four times daily, measuring how much air you can breathe into your lungs), oxygen checks daily, oxygen tubing changes monthly, blood glucose monitoring daily, vital sign monitoring, shower assistance, perineal care, linen changes, and housekeeping.

R1's Service Recap Summary dated October 7, 2022, through November 7, 2022, indicated staff administered medications eight times daily, and

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oxygen checks occurred twelve times daily.

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen) lying in bed. Unlicensed personnel (ULP)-G assisted R1 to a seated position to administer R1's morning medications.

R1's Service Plan did not include medication administration eight times daily and oxygen checks 12 times daily.

On November 8, 2022, at 1:07 p.m., clinical nurse supervisor (CNS)-B confirmed R1's Service Plan had not been updated to reflect the current services being provided. CNS-B stated she does not complete the Service Plans, adding resident services (RS)-I completed the service plans/agreements.

R3
R3 was admitted for services on June 5, 2019.

R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R3's service plan dated March 21, 2022, indicated R3 received services to include medication administration, dressing, showering, toileting, skin treatment, vital sign monitoring, laundry, and housekeeping.

R3's Service Recap Summary dated October 2022, indicated staff conducted glucose (sugar) checks twice daily, wound care to R3's left foot daily and one-to-one visits daily.

On November 8, 2022, at 6:55 a.m., the surveyor

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01640	Continued From page 75 observed ULP-E complete showering assistance and a wound dressing change for R3. R3's Service Plan did not include transfer assistance, glucose checks daily, wound care daily and one-to-one visits. R10 R10 was admitted for services on August 16, 2018. R10's diagnoses included anoxic brain injury second to heroin, seizure disorder, and myocardial infarction second to heroin. R10's service plan dated March 15, 2022, indicated R10 received services to include medication administration, dressing, grooming, showering, toileting, behavior monitoring, vital sign monitoring, laundry, and housekeeping. On November 8, 2022, at 9:18 a.m., the surveyor observed ULP-E with the assistance of a second ULP, use a Hoyer mechanical lift to transfer R10. ULP-E assisted R10 with repositioning and an incontinence brief change. R10's Service Recap summary dated October, 2022, indicated staff conduct one-to-one visits every Friday and as time allows during the week. R10's Service Plan did not include mechanical transfers, repositioning, and one-to-one visits. On November 10, at 2:26 p.m., CNS-B stated service agreements/plans were completed once a year, "so they are going to be different." On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A	01640		

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01640	Continued From page 76 stated they (facility) were not aware of the requirements regarding service plans/agreements. LALD-A added the facility now has a better understanding of the requirements for service plans. The licensee's Service Plan policy revised and dated February 5, 2022, indicated all residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=I	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 relating to the administration of medications; (4) identification of persons responsible for	01730		

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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 have available as needed (PRN) Narcan (medication is used for the emergency treatment of known or suspected opioid overdose) for two of two residents (R10, R1) who were at risk for opioid overdose. Additionally, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis for two of two residents (R1, R6, R3). The licensee also failed to provide specific resident instructions for one of one resident (R1) regarding a

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BIRCHVIEW GARDENS ASSISTED LIV	**108 3RD STREET NORTH HACKENSACK, MN 56452**

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nebulized medication.

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:

During the entrance conference on November 7, 2022, at 12:13 p.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility.

NARCAN UNAVAILABLE

R10
R10's diagnoses included anoxic brain injury secondary to heroin use, seizure disorder, encephalopathy prolonged, and myocardial infarction secondary to heroin use.

R10's Service Plan dated March 15, 2022, indicated services to include medication assistance.

R10's physician orders, certified and active August 19, 2022, to August 19, 2023, included:
- Narcan 4 milligram (mg)/actuation (ACT), instill one (1) spray into one nostril as needed for somnolence, inability. Seek emergency care immediately after use. Up to one (1) time daily.

R10's medication administration record (MAR) dated October 2022 included PRN:

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- Narcan 4 milligram (mg)/actuation (ACT), instill one (1) spray into one nostril as needed for somnolence, inability. Seek emergency care immediately after use. Up to one (1) time daily.

R10's Individual Abuse Prevention Plan (IAPP) dated August 12, 2021, updated February 9, 2022, May 10, 2022, August 2, 2022, and October 29, 2022, indicated R10 had a history of alcohol and substance abuse and "pocketing" medications in cheeks.

On August 12, 2021, RN-J entered the following information into R10's IAPP:
- "has a history of suicide attempt with a transfer belt. Went to off sale and got drunk - fell off the curb, face planted and had to go to ER. Does not make wise choices. Leaves facility in wheelchair does not let staff know where she is going, went to local hotel with ex-boyfriend, was found by police with bottles of alcohol in the hotel room and had to be taken to the ER due to intoxication and unknown other substances."

R10's record included the following progress notes entered by staff:
- May 20, 2022, R10 left the facility without telling staff or signing out and was later wheeled back to the facility by a community member and was "shaking extremely bad."
- July 14, 2022, indicated a late entry by RN-C, "resident returned from parade not sure the time on Tuesday, July 12. Staff reported that resident was flopping like a jelly fish in her wheelchair. Staff also reported that resident seemed like she was high on something, not sure what."

On November 9, 2022, at 1:05 p.m., clinical nurse supervisor (CNS)-B stated there were two residents with a PRN order for Narcan at the

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facility, R1 and R10. The surveyor observed CNS-B go the locked medication room to look for the R10's Narcan. CNS-B did not locate R10's Narcan in the locked storage room. CNS-B went to the locked medication cart and looked through the top drawer of the medication cart. CNS-B was unable to locate R10's PRN Narcan in the medication cart. CNS-B asked unlicensed personnel (ULP)-K where R10's PRN Narcan might be located. ULP-K pointed to the top drawer of the medication cart. CNS-B stated there was no PRN Narcan available.

R1
R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, anemia, and congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services included medication administration.

R1's MAR dated October 2022 included PRN:
- Narcan 4 milligram (mg)/0.1 ml nasal spray (daily) Place spray into one (1) nostril as needed for suspected opioid overdose. Use 2nd device in other nostril after two (2)-three (3) minutes if no/minimal response.

R1's prescriber order dated May 4, 2022, included:
- Narcan 4 milligram (mg)/actuation (ACT), instill one (1) spray into one nostril as needed for suspected opioid overdose. Second device in other nostril after two (2)-three (3) minutes if no/minimal response.

On November 8, 2022, at 10:53 a.m., CNS-B confirmed R1's Narcan expired on September 20, 2022.

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MEDICATION SUPPLIES/REORDERING

R1
R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, anemia, gastroesophageal reflux disease, and congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services included medication assistance.

On November 8, 2022, at 8:06 a.m., the surveyor observed ULP-G obtain R1's morning medication from a locked medication cart. ULP-G referred to R1's MAR to dispense the medications: ferrous gluconate (supplement) 324 milligrams (mg), acetaminophen (pain) 650 mg, aripiprazole (mental conditions) 5 mg, calcium with vit D (supplement) 600 mg, slow mag with calcium (supplement), Lasix (fluid retention) 40 mg, carvedilol (heart failure) l6.25 mg, metformin (diabetes) 500 mg, omeprazole (GERD) 40 mg, aspirin (heart health) 81 mg, prednisone (inflammation) 5 mg, Eliquis (to prevent blood clots) 5 mg, levothyroxine (thyroid) 112 micrograms (mcg), isosorbide mononitrate (heart/relax blood vessels/) 30 mg, and Trelegy Ellpta (COPD) 100/62.5/25 1 puff into lungs.

R1's MAR dated November 1, 2022, through November 7, 2022, included entries for docusate sodium (Colace) 100 mg, take two (2) daily and lidocaine 4% topical patch, place one (1) patch onto the skin every 24 hours, remove patch after 12 hours.

On November 8, 2022, at 8:13 a.m., ULP-G went into the medication storage room to look for Colace. ULP-G was unable to locate any Colace for R1.

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01730	Continued From page 82 On November 8, 2022, at 8:14 a.m., the surveyor observed ULP-G administer R1's morning medications. On November 8, 2022, directly following the above observation, the surveyor reviewed R1's MAR with ULP-G. ULP-G scrolled through R1's MAR. The lidocaine 4% topical patch administration was discussed. ULP-G stated the patch was not available and started to scroll through R1's MAR to indicate the length of time the patch had been marked "skipped/out of stock, nurse notified." ULP-G added, "I can go further [scrolling through R1's MAR]" indicating the dates the patch was missed continued. R1's Colace 100 mg give two tablets order had been marked "skipped/out of stock, nurse notified" on November 1, 2022, through November 8, 2022. R6 R6's diagnoses included heart valve replacement, long term use of anticoagulants, and idiopathic peripheral neuropathy. On November 8, 2022, at approximately 7:00 a.m., the surveyor observed ULP-E assist R6 with removal of oxygen supplementation via nasal cannula. R6's MAR dated October 2022, indicated R6's physician ordered Vitamin C 1000 milligram (mg) take one (1) tab by mouth twice daily, take with methenamine to reduce urinary tract infection (UTI). R6's MAR indicated Vitamin C and methenamine 1 gram (g) take one (1) tab by mouth twice daily with meals, was scheduled at 8:00 a.m. and 5:00 p.m. daily. R6's MAR dated October 2022, indicated R6 did not receive Vitamin C 1000 mg with the scheduled dose of	01730		

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methenamine on the following dates:

October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, 2022, staff indicated in medication documentation "skipped, med out of stock, nurse notified."

R3
R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R3's service plan dated March 21, 2022, indicated R3 received services to include medication administration.

On November 8, 2022, at 7:08 a.m., the surveyor observed ULP-E administer R3's morning medications.

R3's prescriber orders dated August 10, 2022, included aspirin 81 mg daily, cilostazol 100 mg twice daily, citalopram 20 mg daily, clopidogrel 75 mg daily, Ensure 8 ounces twice daily, Gabapentin 300 mg three times daily, iodosorb 40 mg daily to left heel, Losartan 25 mg daily, Metoprolol extended release (ER) 25 mg daily and simvastatin 10 mg daily.

R1, R6, and R3's Individualized Medication Management Plans (IMMP) dated respectively November 3, 2022, April 11, 2022, and February 14, 2022, lacked:

- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis.

On November 8, 2022, at 11:42 a.m., CNS-B

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stated it is the med tech's responsibly to reorder medications. RN-C added the pharmacist communicates with the "MD" (medical doctor) to get orders signed. CNS-B commented, "I would hope staff would let me know when medications are missing."

On November 10, 2022, at 2:32 p.m., CNS-B stated R1 had a more current IMMP, one dated October 7, 2022. CNS-B looked R1's IMMP plan and stated, "no, it [monitoring/reordering medication] is not there."

SPECIFIC RESIDENT INSTRUCTION

R1's MAR dated October 2022 included: ipratropium-albuterol (relaxing and opening the air passages to the lungs) 0.5 mg-3 mg (2.5mg/3ml) give 1 unit does for nebulization (system that changes liquid medicine into fine droplets (in aerosol or mist form) that are inhaled through a mouthpiece or mask) twice daily.

R1's prescriber's order dated May 2, 2022, included an order for ipratropium-albuterol 0.5 mg-3 mg (2.5mg/3ml) give 1 unit does for nebulization twice daily.

R1's record lacked documentation of speific resident instructions relating to the administration of nebulizer treatments.

On November 10, 2022, at 2:32 p.m., CNS-B confirmed R1's ITTP lacked instructions for when to call the nurse and specific instructions for nebulizer treatments. CNS-B confirmed R1's record lacked specific instructions for nebulizer treatments, adding, "it [mask use or mouthpiece] changes depending on his insurance."

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01730	Continued From page 85 The licensee's Medication Management Services policy dated August 1, 2021, indicated the RN was responsible for the implementation of the facility's medication management policies and procedures. Based on the nursing assessment, the RN would develop an individualized medication management plan for each client receiving any type of mediation management services, consistent with current practice standards and guidelines, and would develop specific procedures for medication management services that staff would provide. Medication management services the facility would offer may include: medication set ups, administration of medications, storing and securing medication, documenting medication activities, verifying and monitoring effectiveness of systems to ensure safe handling and administration, coordination refills, communicating with the pharmacy about the client's medications, coordinating and communicating with the prescriber, and communicating with the client, the client's representative and, when appropriate, the client's family. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for standing order medications for six of six residents (R6, R1, R3, R8, R15, R16) whose medication administration was delegated to unlicensed personnel.

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:

R6
R6's diagnoses included heart valve replacement, long term use of anticoagulants, and idiopathic peripheral neuropathy.

R6's Service Plan dated November 7, 2022, indicated R6 received services to include medication administration.

R6's medication administration summary (MAR) dated October 2022, indicated R6's standing PRN (as needed) medication orders included:

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- acetaminophen or ASA (aspirin) 650 (mg). May alternate ASA or acetaminophen every two (2) hours. Notify physician if temperature persists over 24 hours. No ASA if resident is on coumadin. Acetaminophen not to exceed 4000 mg/24 hours.

R6's October 2022 MAR indicated R6 was administered Coumadin (warfarin) (a blood thinner) 4 (mg) Monday and Friday, 3 (mg) all other days. R6's MAR indicated staff administered the PRN acetaminophen/ASA on the following dates in October:
October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 31, 2022.

R6's October 2022 MAR lacked identification of which PRN medication, acetaminophen, or aspirin, was administered on the following dates: October 8, 9, 10, 11, 12, 13, 14, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 31, 2022.

R1
R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, anemia, gastroesophageal reflux disease, and congested heart failure.

R1's Service Plan dated March 14, 2022, indicated R1 received services to include medication administration.

On November 8, 2022, at 8:06 a.m., the surveyor observed unlicensed personal (ULP)-G administer R1's morning medication.

R1's prescriber order dated May 4, 2022, included acetaminophen or ASA (aspirin) 650 mg by mouth as needed, may alternate ASA or acetaminophen every 2 hours. Notify physician if

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temp persists over 24 hours. No ASA if resident is on Coumadin, acetaminophen not to exceed 4000 mg/24 hrs.

R3
R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R3's service plan dated March 21, 2022, indicated R3 received services to include medication administration.

On November 8, 2022, at 7:08 a.m., the surveyor observed ULP-E administer R3's morning medications.

R3's prescriber order dated August 10, 2022, included acetaminophen or ASA (aspirin) 650 mg by mouth as needed, may alternate ASA or acetaminophen every 2 hours. Notify physician if temp persists over 24 hours. No ASA if resident is on Coumadin, acetaminophen not to exceed 4000 mg/24 hrs.

R8
R8's diagnoses included diabetes, anxiety, atrial fibrillation, major depressive disorder, heart failure, insomnia, and cognitive impairment.

R8 Service Plan dated March 14, 2022, indicated R8 received services to include medication administration.

R8's prescriber order dated January 1,2022, included acetaminophen or ASA (aspirin) 650 mg by mouth as needed, may alternate ASA or acetaminophen every 2 hours. Notify physician if temp persists over 24 hours. No ASA if resident is on Coumadin, acetaminophen not to exceed

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01750	Continued From page 89 4000 mg/24 hrs. On November 8, 2022, at 7:47 a.m., the surveyor observed ULP-D apply compression stockings to R8's legs. R15 R15's diagnoses included alcohol abuse, diabetes mellitus type II and depressive episodes. R15's service plan dated April 1, 2022, indicated R15 received services to include medication administration. R15's prescriber order dated September 27, 2022, included acetaminophen or ASA (aspirin) 650 mg by mouth as needed, may alternate ASA or acetaminophen every 2 hours. Notify physician if temp persists over 24 hours. No ASA if resident is on Coumadin, acetaminophen not to exceed 4000 mg/24 hrs. R16 R16's diagnoses included dementia, diabetes, and hypertension (elevated blood pressure). R16's service plan dated March 14, 2022, indicated R16 received services to include medication administration. R16's prescriber order dated July 5, 2022, included acetaminophen or ASA (aspirin) 650 mg by mouth as needed, may alternate ASA or acetaminophen every 2 hours. Notify physician if temp persists over 24 hours. No ASA if resident is on Coumadin, acetaminophen not to exceed 4000 mg/24 hrs. The licensee failed to provide resident-specific instructions pertaining to PRN	01750		

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01750	Continued From page 90 acetaminophen/aspirin (ASA) combined standing orders. The standing order medication did not include instructions for which medication, acetaminophen or aspirin, unlicensed personnel were to administer, and under what conditions each medication were to be administered. On November 8, at 12:04 p.m., clinical nurse supervisor (CNS)-B stated the acetaminophen/aspirin (ASA) was a medication order that would be in the standing orders for all residents. The licensee's Administration and Documentation fo (sic) PRN and Standing Order Medications policy dated August 1, 2021, indicated PRN medications would be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the RN for the administration and documentation of the PRN/Standing Order (SO). Staff would administer PRN/SO medications exactly as prescribed and would document administration of PRN/SO medications on the form required by the RN and would contact the supervising nurse if the staff person or resident had any questions or concerns about the PRN medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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 staff administered scheduled medications as ordered for two of five residents (R6, R1) and as needed (PRN) for two of five residents (R8, R6). In addition, the licensee failed to ensure the steps of the medication administration process were followed for one of two employees, (unlicensed personnel (ULP)-G) observed during medication administration.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

MEDICATIONS NOT ADMINISTERED AS ORDERED

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R6
R6's diagnoses included heart valve replacement, long term use of anticoagulants, and idiopathic peripheral neuropathy.

R6's Service Plan dated November 7, 2022, indicated R6 received services to include medication administration.

R6's medication administration summary (MAR) dated October 2022, indicated R6's physician ordered Vitamin C 1000 milligram (mg) take one (1) tab by mouth twice daily, take with methenamine to reduce urinary tract infection (UTI). R6's MAR indicated Vitamin C and methenamine 1 gram (g) take one (1) tab by mouth twice daily with meals, was scheduled at 8:00 a.m. and 5:00 p.m. daily.

R6's October 2022 MAR indicated staff did not administer R6's Vitamin C doses as scheduled on the following dates and times:
- 8:00 a.m., October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, 2022 - "skipped - med out of stock, nurse notified."
- 5:00 p.m., October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 2022 - "skipped - med out of stock, nurse notified."

R1
R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, anemia, gastroesophageal reflux disease, and congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services included medication assistance nine

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times daily.

On November 8, 2022, at 8:06 a.m., the surveyor observed ULP-G obtain R1's morning medication from a locked medication cart. ULP-G referred to R1's MAR to dispense the medications: ferrous gluconate (supplement) 324 milligrams (mg), acetaminophen (pain) 650 mg, aripiprazole (mental conditions) 5 mg, calcium with vit D (supplement) 600 mg, slow mag with calcium (supplement), Lasix (fluid retention) 40 mg, carvedilol (heart failure) 6.25 mg, metformin (diabetes) 500 mg, omeprazole (GERD) 40 mg, aspirin (heart health) 81 mg, prednisone (inflammation) 5 mg, Eliquis (to prevent blood clots) 5 mg, levothyroxine (thyroid) 112 micrograms (mcg), isosorbide mononitrate (heart/relax blood vessels/) 30 mg, Trelegy Ellpta (COPD) 100/62.5/25 1 puff into lungs.

On November 8, 2022, at 8:13 a.m., ULP-G went into the mediation storage room to look for Colace. ULP-G was unable to locate any Colace for R1.

On November 8, 2022, at 8:14 the surveyor observed ULP-G administer R1's morning medications.

R1's October and November 2022 MARs indicated staff did not administer R1's lidocaine 4% topical patch, place 1 patch onto the skin every 24 hours, remove patch after 12 hours on the following dates and times:
8:00 a.m., October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 2022 - "skipped - med out of stock, nurse notified."
8:00 a.m., November 1, 2, 3, 4, 5, 6, 7, 2022 - "skipped - med out of stock, nurse notified."

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R1's October and November 2022 MARs indicated staff did not administer R1's docusate sodium (Colace) 100 mg, take 2 daily on the following dates and times:
8:00 a.m., October 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 2022 - "skipped - med out of stock, nurse notified."
8:00 a.m., November 1, 2, 3, 4, 5, 6, 7, 2022 - "skipped - med out of stock, nurse notified."

On November 8, 2022, directly following R1's medication administration, the surveyor reviewed R1's MAR with ULP-G. ULP-G scrolled back through R1's MAR. R1's lidocaine 4% patch had been marked "skipped/out of stock, nurse notified" as far back as ULP-G had scrolled. ULP-G stated, "I can go further" (to continue to look at R1's MAR for lidocaine patch administration, indicating it had been marked not given for a longer period of time). R1's Colace 100 mg give two daily medications, had been marked as "skipped/out of stock, nurse notified," every day in November and most days in October.

On November 8, 2022, at 11:42 a.m., clinical nurse supervisor (CNS)-B reviewed R1's MAR with the surveyor. The last time R1's lidocaine patch was reordered/filled was September 20, 2022. CNS-B added she was not sure when it ran out. CNS-B confirmed R1 did not receive Colace or lidocaine patch as prescribed.

AS NEEDED (PRN) MEDICATIONS AND MEDICATION DOCUMENTATION

R8
R8's diagnoses included diabetes, anxiety, atrial

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fibrillation, major depressive disorder, heart failure, insomnia, and cognitive impairment.

R8's Service Plan dated March 14, 2022, indicated the resident received the following service: medication assistance ten times per day, skin care two times a day, and skin treatment two times per day.

R8's prescriber's orders dated January 6, 2022, included an order for A & D topical ointment [skin protectant] as needed (PRN), apply thin layer to reddened or rash areas of skin.

On November 8, 2022, at 7:42 a.m., the surveyor observed ULP-D assist R8 with morning cares. ULP-D checked the brief R8 was wearing. ULP-D went to the sink in the bathroom to get a washcloth and a dry hand towel. ULP-D removed the brief R8 had on and placed the brief into a trash bag. There was some light soiling in the brief, and it appeared to be wet. ULP-D cleansed R8's perineal area with the washcloth. ULP-D went to the sink to rinse the washcloth in a basin. ULP-D went back to R8 to complete R8's perineal care and dried the area with the hand towel. ULP-D looked in R8's room for "cream" [skin protectant]. ULP-D was not able to locate any "cream" in R8's room and commented, "at least you [R8] are not super red."

On November 8, 2022, at approximately 2:30 p.m., CNS-B stated when ointments are not in the room and available for use, ULPs should either go and get the medication or the ULP should call another ULP to request the ointment be brought to the room, "not just comment, we [facility] are out."

R6

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R6's MAR dated October 2022, indicated R6's standing PRN medication orders included: acetaminophen or ASA (aspirin) 650 (mg). May alternate ASA or acetaminophen every two (2) hours. Notify physician if temperature persists over 24 hours. No ASA if resident is on Coumadin. Acetaminophen not to exceed 4000 mg/24 hours.

R6's October 2022 MAR indicated R6 was administered Coumadin (warfarin) (a blood thinner) 4 (mg) Monday and Friday, 3 (mg) all other days. R6's MAR indicated staff administered the PRN acetaminophen/ASA on the following dates in October:
October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 31, 2022.

R6's October 2022 MAR lacked identification of which PRN medication, acetaminophen or aspirin, was administered on the following dates: October 8, 9, 10, 11, 12, 13, 14, 17, 18, 21, 22, 23, 24, 25, 26, 27, 28, 31, 2022.

MEDICATION ADMINISTRATION PROCESS

ULP-G
On November 7, 2022, at 11:26 a.m., the surveyor observed ULP-G obtain R2's blood glucose level and administer R2's noon medication. ULP-G failed to document the services delivered at the time they were completed. The surveyor observed ULP-G immediately begin to assist another resident.

Directly following the above observation ULP-G confirmed she did not document at the time the tasks were completed. ULP-D stated she was to document "right away, right away."

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01760	Continued From page 97 On November 7, 2022, registered nurse (RN)-C stated ULP's should document when they [ULP] are finished with "current person." The licensee's Documentation of Medication Services on The MAR policy dated August 1, 2021, indicated assistance with medications, including medication reminders, assistance with self-administration of medications and medication administration, would be documented immediately on the client's [resident's] MAR after completion of the task, according to the home care licensing requirements and professional standards of documentation. The licensee's Administration and Documentation fo (sic) PRN and Standing Order Medications policy dated August 1, 2021, indicated PRN medications would be administered consistent with the parameters specified in the prescriber's prescription and with the procedures identified by the RN for the administration and documentation of the PRN/Standing Order (SO). Staff would administer PRN/SO medications exactly as prescribed and would document administration of PRN/SO medications on the form required by the RN and would contact the supervising nurse if the staff person or client had any questions or concerns about the PRN medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770		

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Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R12, R16).

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 November 7, 2022, at approximately 12:15 p.m., registered nurse (RN)-C stated the licensee provided medication management services to residents to include medication set up services.

R12's diagnoses included diabetes, hypertension, dementia, and mood disorder.

R12's Service Plan dated March 14, 2022, noted services to include medication assistance six times per day. R12's service plan did not include medication set up.

R12's prescriber orders dated February 16, 2022,

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included hydromorphone (moderate to serve pain)1 milligrams (mg)/ milliliter (ml) give, 1 ml/mg every two hours, by mouth (po) as needed (prn) and lorazepam (Ativan-anxiety) 2 mg/ml give 0.25 ml/0.5 mg every 4 hours as needed.

On November 7, 2022, during a review of the medication cart the surveyor observed six syringes of hydromorphone 1 mg/1ml and 12 syringes of 0.25 mg/ 0.5 ml Ativan for R12.

R12's Pill Count History form dated October 1, 2022, to November 7, 2022, included the medication count at shift change/amount remaining, time and date, name of the staff and witness counting the medication and when medication was received (added to the count). The form also included the name of the medication, dosage, and when to administer.

R12's record lacked the name and title of the person pre-filling the syringes. In addition, the tracking form lacked the medication route for the Ativan syringes.

On November 7, 2022, at 3:46 p.m., RN-C stated they use the narc log (Pill Count History) when setting up R12's syringes. The syringes are drawn up and then two RNs add the syringes into the narcotic log. RN-C confirmed they use the same process when setting up all controlled syringes.

R16
R16's diagnoses included HTN, diabetes, diabetic neuropathy, chronic kidney disease, and dementia without behavioral disturbance.

R16's Service Plan dated May 10, 2022, noted services to include medication assistance,

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01770	Continued From page 100 medication set up, medication ordering, anxiety redirection, and daytime wellbeing checks. R16's prescriber orders dated March 22, 2022, include two diabetic medications, three heart medications, one supplement, one cholesterol medication, and one medication for neuropathy. On November 8, 2022, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-G remove seven pills from a pre-filled seven-day medication planner (dosage box) and administer the medication to R16. R16's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, quantity of dose, times to be administered, and route of administration. On November 9, 2022, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated "I am going to be honest; this is what we do. Go into the MAR (medication administration record) on here [computer screen] and pull up each medication by name and fill it for the week and check a box completed." The licensee's Medication Administration System-Dosage Box Set-Up policy dated August 1, 2021, indicated the RN or licensed practical nurse (LPN) would transcribe the medication prescription onto the MAR. For medication included in the dosage box, the day and time of administration would be noted on the MAR. Medications that could not be set up in the dosage box (topical or liquid) would be recorded on the MAR to include any special instructions and the MAR would include: medication name and strength, storage, dosage to be administered,	01770		

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01770	Continued From page 101 date and time of administration, route of administration, drug classification and special precautions, and any specific instructions for administering the medication to the client. When the RN or LPN had completed setting up the medications into the dosage box, the nurse would document each individual medication that had been set up on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=D	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 medication was secured in a manner to that would permit only authorize personnel to have access for one of five 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).	01880		

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The findings include:

On November 7, 2022, at 3:55 p.m., the surveyor requested to check the date of R1's as needed (PRN) nitroglycerin (for chest pain) 0.4 milligrams (mg) tablets. Unlicensed personnel (ULP)-G checked the medication cart and was not able to find the nitroglycerin. ULP-G replied, "well maybe he has it with him." The surveyor and ULP-G went to R1's room and found R1's nitroglycerin medication in R1's walker.

R1's individualized Medication Management Plan dated April 11, 2022, indicated all of R1's medications would be locked on medication cart or locked in medication room.

On November 7, 2022, at 4:10 p.m., registered nurse (RN)-C stated R1's nitroglycerin should have been stored in the locked medication cart.

The licensee's Storage of Medications policy dated August 1, 2021, indicated a registered nurse must conduct a nursing assessment of a client's [resident's] need for medication management services, including the appropriate method to store the client's medication and whether secured storage was appropriate given the client's functional and cognitive status, concerns about the potential for drug diversion or other considerations. Based on this assessment, the RN would develop an individualized medication management plan for the client that would address storage of the client's medications.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01890 SS=E	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 date time-sensitive medications with an opened or expiration date for five of five residents (R1, R7, R9, R11, R13). In addition, the licensee failed to monitor for expired medication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: TIME SENSITIVE MEDICATIONS On November 7, 2022, at 1:06 p.m., 2022, the surveyor reviewed the medication cart with registered nurse (RN)-C. RN-C confirmed the following:	01890		

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01890	Continued From page 104 - R1's opened Trelegy Ellipta 100 micrograms (mcg)/62.5 mcg/25 mcg inhaler (steroid bronchodilator) did not have a label which indicated the date the inhaler had been removed from the foil tray and when the inhaler would expire. The manufacturer's instructions for Trelegy Ellipta dated January 2019, directed to discard the inhaler six weeks after it had been removed from the foil tray. - R7's opened bottle of latanoprost 0.005% ophthalmic (eye) solution (glaucoma medication) did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. The manufacturer's instructions for latanoprost eye solution dated October 2019, directed to discard any unused solution after 42 days. - R9's opened timolol maleate (used to treat high pressure inside the eye) 0.5 % solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. The manufacturer's instructions for timolol maleate (eye pressure) dated March 20, 2022, directed to discard solution 28 days after opening the bottle. - R11's opened Incruse Ellipta 62.5 mcg (inhaler that works by relaxing muscles in the airways to improve breathing) did not have a label which indicated the date the inhaler had been removed from the foil tray and when the inhaler would expire.	01890		

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01890		01890		

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The manufacturer's instructions for Incruse Ellipta inhaler dated 2017, directed to store in the original package container in order to protect from moisture and do not open the foil lid until ready to inhale for the first time. Safely throw away the inhaler six weeks after you open the foil tray or when your counter reads "0", whichever comes first.

- R13's opened bottle of sterile water.

The manufacturer's instructions for sterile water dated November 20, 2020, directed to discard sterile water within 24 hours of opening.

On November 7, 2022, at 2:21 p.m., RN-C confirmed R13's sterile water was lacking an open date. RN-C added she was "kind of mad at staff right now, they know better."

The licensee's Storage of Medications policy dated August 1, 2021, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quality of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01940	Continued From page 106	01940		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop individual treatment management plans with all required content for three of five residents (R1, R3, R6)	01940		

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who received ordered treatments.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During an interview on November 7, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents.

R1's diagnoses included chronic pulmonary disease, coronary artery disease, anemia, and congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services to included incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully, measuring how much air you can breathe into your lungs), oxygen checks, blood glucose monitoring daily, and vital sign monitoring.

R1's prescriber's order dated May 2, 2022, included monitoring oxygen saturations two times per day and incentive spirometer four times daily.

R1's prescriber's order dated September 13, 2022, included oxygen administration 2 liters per

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minute via nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen).

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal cannula lying in bed while unlicensed personnel (ULP)-G administered R1's morning medication.

R1's record lacked an Individualized Treatment and Therapy Plan (ITTP) to include the following:
- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and
- any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.

On November 10, 2022, at 2:34 p.m., CNS-B confirmed R1's ITTP lacked instructions for when to call the nurse for R1s incentive spirometer and oxygen level via SPO2 monitoring (measure oxygen using a pulse oximeter, which consists of a computerized monitor and probe. The probe may be attached to a patient's finger toe, nostril, or earlobe. The monitor then displays a reading of how saturated the patient's blood is with oxygen).

R3
R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease.

R3's Service Recap Summary dated October 2022, indicated R3 received treatment services to include glucose (sugar) checks and wound care.

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R3's physician orders dated August 11, 2022, indicated R3 received treatment services to include glucose checks twice daily and wound care once daily.

On November 8, 2022, at 6:55 a.m., the surveyor observed ULP-E complete showering assistance and a wound dressing change for R3.

R3's record lacked an ITTP to include the following:
- a statement of the type of services that will be provided;
- documentation of specific resident instructions relating to the treatments or therapy administration;
- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and
- any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.

R6
R6's diagnoses included heart valve replacement, long term use of anticoagulants, and depression.

R6's Service Recap Summary dated October 2022, indicated R6 received treatment services to include brace and splint placement to ankles/feet on in the morning, off at night, and oxygen supplementation via nasal cannula at bedtime.

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01940	Continued From page 110 R6's record lacked an ITTP to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy updated February 5, 2022, indicated when a treatment or therapy is delegated or assigned to unlicensed personnel, the RN must develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of Minnesota statutes 144.4793, subd. 3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies	01950		

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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
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure 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 for two of two employees (ULP-D, ULP-G) assisting with R1's incentive spirometer .

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).

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The findings include:

R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, anemia, congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services to include incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully. It measures how much air you can breathe into your lungs) four times a day, oxygen saturations monitoring two times daily, and oxygen checks daily.

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen) lying in bed while ULP-G administered R1's oral morning medication and R1's inhaler.

On November 8, 2022, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated she remembered the order for the incentive spirometer for R1 began, "on hospital return."

On November 9, 2022, at 12:58 p.m., CNS-B verified ULP-G nor any of the staff working at the facility were trained on the incentive spirometer or demonstrated the ability to follow the procedure to assist R1 with the incentive spirometer.

The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated August 1, 2021, indicated training and competency evaluations of unlicensed personnel must be conducted by a RN or other instructor in conjunction with the RN. Other Licensed Health Professionals may train and conduct competency

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01950	Continued From page 113 evaluation of unlicensed personnel for tasks that can be delegated by the Licensed Health Professional with his/her professional scope of practice. Training on all delegated tasks or assigned therapies that the unlicensed personnel will perform (practical skills test showing competency is required). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of three residents (R1) with oxygen administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01960		

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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 included chronic obstructive pulmonary disease, coronary artery disease, anemia, and congested heart failure.

R1's Service Plan, dated March 14, 2022, noted services to include incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully, measuring how much air you can breathe into your lungs), oxygen checks, vital sign monitoring, and medication assistance.

R1's prescriber's orders dated September 13, 2022, included oxygen flow rate 2 liters per minute (lpm).

R1's medication administration record (MAR) dated November 1, 2022, through November 7, 2022, included:
- oxygen (daily) 2 liters per minute (lpm), administer oxygen at 3 lpm via nasal cannula (a lightweight tube placed in the nostrils to deliver supplemental oxygen).

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 wearing a nasal canulalying in bed while ULP-G administered R1's morning medication.

On November 9, 2022, at 12:32 p.m., clinical nurse supervisor (CNS)-B confirmed the entry on R1's MAR for oxygen administration dated

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01960	Continued From page 115 November 1, 2022, through November 7, 2022, had been incorrect, adding she changed the MAR to reflect the correct amount of oxygen to be administered yesterday. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated August 2021, indicated the RN or appropriate Licensed Health Professional was responsible for assuring that current, authorized prescriber prescriptions for medication and orders for treatments and therapies, to be administered by the staff were kept in the client's record and that changes in ores were addressed in the client's care plan, service plan and Medication Administration Record, and were communicated on a timely basis to all appropriate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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.	02040		

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02040	Continued From page 116 This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 8, 2022, at approximately 12:45 p.m., documents were provided for review. Documents were reviewed by survey staff on November 8, 2022, between 12:45 p.m. and 2:30 p.m. A hazard vulnerability or safety risk assessment had not been performed on and around the property. The LALD-(A) confirmed the findings during the exit interview on November 8, 2022, at approximately 2:30 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	02110		

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02110	Continued From page 117 (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or	02110		

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the resident's legal and designated representatives for three of three residents (R3, R12, R16).

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:

The facility held a current Assisted Living with Dementia Care license.

On November 7, 2022, at approximately 12:15 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee was not providing dementia care and had reached out to Minnesota Department of Health (MDH) to inquire about a license change. The licensee did not have the following required dementia policies:
- wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
- description of family support programs and efforts to keep the family engaged;
- limiting the use of public address and intercom systems for emergencies and evacuation drills only; and
- safekeeping of residents possessions.

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02110	Continued From page 119 R3 R3 was admitted for services on June 5, 2019. R3's diagnoses included vascular dementia, major depressive disorder, and peripheral artery disease. R12 R12 was admitted for services on March 23, 2021. R12's diagnoses included dementia, diabetes, and hypertension (HTN-high blood pressure). R16 R16 was admitted for services on March 23, 2021. R16's diagnoses included dementia, diabetes, and depression. On November 9, 2022, at 12:48 p.m., clinical nurse supervisor (CNS)-B stated the facility gives the dementia polices "in the packet" at the time of admission. CNS-B confirmed none of the resident's records would have evidence the dementia policies were received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

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(1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

On November 7, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated she was the clinical supervisor that oversees the licensee's registered nurses (RN)'s, unlicensed staff, and provides direct oversight and clinical nursing cares for the licensee's residents.

On November 8, 2022, at 10:37 a.m., the surveyor requested documentation of the required competency and knowledge test for dementia training from CNS-B.

On November 8, 2022, at approximately 10:40

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02140	Continued From page 121 a.m., CNS-B stated, "to be honest, I have no idea what you're talking about." CNS-B inquired what the requirement was and stated, "no, I wasn't aware we had to have anything like that." No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the residency agreement contract language which limited the rights of five of five residents (R1, R2, R3, R6, R14). This had the potential to affect all residents and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1, R2, R3, R6 and R14's assisted living contract	02290		

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signed and dated respectively, January 17, 2022, May 4, 2022, February 24, 2022, January 31, 2022, and July 22, 2022, included language on pages 18-19 titled House Rules. The House Rules section indicated 12 numbered items that residents were required to follow in order to remain a resident of licensee's facility and included:

- visitors are always welcome at [facility name] 24/7 (except when under state mandated closure or under quarantine rules). Overnight guests will be allowed at the facility to visit only. Overnight guests must be 18 years old or older. Minors must be accompanied by an adult at all times. Guests cannot use [facility name] as a hotel or rest stop. Guests must follow any state or federal laws, and they should follow any terms or rules the resident has agreed to within this agreement. Guests should sign in at the front desk. Guests must pay for any meals or other supplies that they use or consume belonging to [facility name]. Paragraph 1. Page 18.

- there is no drinking of alcoholic beverages. If a resident is believed to have been drinking, the resident agrees under the terms of this contract to take an alcohol detection test and if test is positive medications may be withheld if there are concerns about drug interactions with alcohol. Paragraph 4. Page 18.

On November 10, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A stated the contract reviewed by the surveyor is the current contract used by licensee for all residents and the contract would be reviewed for compliance going forward.

TIME PERIOD FOR CORRECTION: Twenty-One

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02290	Continued From page 123 (21) days	02290		
02310 SS=I	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 four of four residents (R8, R10, R14, R15) with hospital-style bed rails. In addition, based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all residents, visitors, and staff. 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: BEDRAILS	02310	On November 10, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, widespread scope violation.	

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This practice resulted in an immediate correction order on November 8, 2022.

On November 8, 2022, at approximately 8:30 a.m., clinical nurse supervisor (CNS)-B stated 19 of the 39 residents in the facility utilized hospital-style bed rails.

R8
R8's diagnoses included diabetes, anxiety, atrial fibrillation (an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart), major depressive disorder, gastroesophageal reflux disease (GERD-chronic disease that occurs when stomach acid or bile flow irrigates the lining). heart failure, insomnia, and cognitive impairment.

R8 Service Plan dated March 14, 2022, indicated the resident received the following services: dressing assistance, behavior monitoring, cpap cleaning (continuous positive airway pressure therapy is a common treatment for obstructive sleep apnea), medication assistance, vital sign monitoring, skin care, transfer assistance, toileting assistance and compression socking assistance (TEDs), housekeeping, and laundry.

On November 8, 2022, at 7:47 a.m., the surveyor observed R8 sitting in a hospital bed which had bilateral bed rails in the raised position. R8 was using one of the bed rails, holding on to it with his left hand, to steady his body while unlicensed personnel (ULP)-D applied TEDs stockings.

R8's assessment dated August 16, 2022, included a section titled Safety;
- bed type: electric;
- bed safety: the bed safety zone assessment is

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not applicable, either resident has no bed rails in use, or has portable bed rails that are installed on a consumer bed.

R8's Risk Agreement-Bed Rails dated July 29, 2022, included the registered nurse (RN)'s statement bed rails: "Zone 1 less than 4.75 inches opening in bed rail, doesn't sleep in his bed." Risk Agreement did not indicate the bed rail purpose.

On November 8, 2022, at approximately 3:00 p.m., CNS-B measured R8's bed rail with surveyor present. The bed rail measured 35 inches long by 17 inches tall with 4 center vertical bars 2.5 inches apart and 6 outer horizontal bars 3 inches apart, which was in compliance with FDA guidelines for bed rails.

R8's resident record did not contain a comprehensive bed rail assessment.

R10
R10's diagnoses included brain injury second to heroin use, depression, and seizure disorder.

R10's Service Plan dated March 15, 2022, indicated the resident received the following services: dressing, grooming, exercises, medication administration, bathing, laundry, and housekeeping.

On November 8, 2022, at 9:12 a.m., the surveyor observed along with ULP-E, R10 lying in a hospital bed with bilateral bed rails in the raised position. ULP-E stated R10 used the bed rails to assist with getting in and out of bed.

R10's assessment dated October 29, 2022, included a section titled Safety;

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- bed type: electric bed;
- mattress type: air bed mattress; and
- the bed safety zone assessment: the bed rail meets FDA guidelines.

R10's Risk Agreement-Bed Rails dated July 15, 2022, included the RN's statement of bed rails: "Zone 1 less than 4.75 inches opening in bed rail."

On November 8, 2022, at approximately 3:00 p.m., CNS-B measured R10's bed rail with surveyor present. The bedrail measured 8 inches tall by 3 inches wide, and 15 inches tall by 2.5 inches wide which was in compliance with FDA guidelines for bed rails.

On November 8, 2022, at 8:06 a.m., CNS-B stated the risk agreement was considered the licensee's bed rail assessment.

R10's resident record did not contain a comprehensive bed rail assessment.

R14
R14's diagnoses included multiple sclerosis (MS), stroke, and thoracic spinal pain.

R14's Service Plan, undated and unsigned, indicated the resident received the following services: dressing, showering, peri-care, medication administration, transfers, laundry, and housekeeping.

On November 8, 2022, at 9:25 a.m., the surveyor observed along with ULP-E, R14 lying in a hospital bed with bilateral bed rails in the raised position. R14 stated she used the bed rails to assist with positioning and getting in and out of bed.

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R14's assessment dated August 19, 2022, included a section titled Safety;
- bed type: electric bed;
- bed rails in use, include description and condition of bed rail: bilateral sides of bed; and
- the bed safety zone assessment: rails under 4.75 inches.

On November 8, 2022, at approximately 3:00 p.m., CNS-B measured R14s bed rail with surveyor present. The bedrail measured 8 inches tall by 3 inches wide, and 15 inches tall by 2.5 inches wide which was in compliance with FDA guidelines for bed rails.

R14's resident record did not contain a comprehensive bed rail assessment or risk education documentation.

R15
R15's diagnoses included hypertension (elevated blood pressure) and diabetes mellitus II.

R15's Service Plan dated April 1, 2022, indicated the resident received the following services: dressing, grooming, behavior monitoring, TEDs, medication administration, bathing, laundry, and housekeeping.

On November 8, 2022, at 10:05 a.m., the surveyor observed R15's hospital bed with bilateral bed rails. R15 stated they used the bed rails for repositioning and getting in and out of bed.

R15's assessment dated September 28, 2022, included a section titled Safety;
- bed type - describe: standard
- mattress type: mattress original to bed;

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- bed safety: the bed safety zone assessment is not applicable, either resident has no bed rails in use, or has portable bed rails that are installed on a consumer bed.

On November 8, 2022, at approximately 3:00 p.m., CNS-B measured R8's bed rail with surveyor present. The bedrail measured 8 inches tall by 3 inches wide, and 15 inches tall by 2.5 inches wide which was in compliance with FDA guidelines for bed rails.

R15's resident record did not contain a comprehensive bed rail assessment or risk education documentation.

On November 8, 2022, at 8:06 a.m., CNS-B stated the risk agreement was considered the licensee's bed rail assessment.

R8, R10, R14, and R15's records lacked a comprehensive assessment on the use of an assistive device and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device.

The licensee's Assessing the Safety of Side Rails policy dated as reviewed February 5, 2022, indicated a staff would alert the RN or licensed professional if a client [resident] has any type of side rail or similar equipment and the RN or licensed professional will then evaluate whether the side rial appears to be safe for the client. The RN or licensed professional would educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side rail does not appear to meet Food and Drug Administration (FDA) standards, the RN or licensed professional would

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recommend the side rail be removed and would recommend alterative options to reduce the risk of a fall out of bed. The RN or licensed professional would document these conversations and recommendations. The RN or licensed professional would review the use of the bedrail during the remonitoring, and reassessment visits every 90 days. While it is not required, the agency may seek a prescriber's order for the use of a bedrail to meet the individual needs/ requests of the clients. Written instructions regarding the use of a side rail would be developed by the RN for licensed professional for unlicensed staff. The policy included information from FDA regarding side rails.

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 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 Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's

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incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:
- Purpose and intention of the bed rail;
- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;
- The resident's bed rail use/need assessment;
- Risk vs. benefits discussion (individualized to each resident's risks);
- The resident's preferences;
- Installation and use according to manufacturer's guidelines;
- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and
- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.

Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations.

On November 10, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remains at widespread scope, level three (I).

OXYGEN TANK STORAGE

R1's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, anemia, chronic kidney disease,

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congested heart failure, hyperglycemia, and mood disorder.

R1's Service Plan, dated March 14, 2022, noted services to include medication assistance nine times daily, incentive spirometer (a device that will expand your lungs by helping you breathe more deeply and fully four times daily, measuring how much air you can breathe into your lungs), oxygen saturation monitoring (checking the level of oxygen in the blood stream using a device that attaching to a finger) two times daily, oxygen checks daily, and oxygen tubing changes monthly.

On November 7, 2022, at 11:18 a.m., the surveyor observed ten oxygen tanks secured in a rack in R1's room, one oxygen tank in a pull along cart/secured, and two oxygen tanks that were unsecured along a wall.

On November 7, 2022, directly following the above observation, registered nurse (RN)-C confirmed the oxygen tanks were to be secured and placed the two unsecured oxygen tanks into the oxygen rank.

On November 8, 2022, at 8:06 a.m., the surveyor observed R1 lying in bed wearing an nasal cannula (a lightweight tube which are placed in the nostrils to deliver supplemental oxygen) and one unsecured tank of oxygen along a wall in R1's room.

On November 8, 2022, at 10:40 a.m., the surveyor observed four non-secured oxygen tanks sitting on the floor near clinical nurse supervisor (CNS)-B's office door.

Directly following the above observation CNS-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 132 stated, the [oxygen tanks] are "stragglers", adding "I wish they [oxygen tanks] would go away." On November 8, 2022, at approximately 10:45 a.m., RN-C acknowledged the oxygen tanks outside of CNS-B's office and the tank in R1's room should have been secured. The facilities Safe Oxygen Use and Storage policy dated August 1, 2021, indicated the RN would educate clients' [residents] client's representatives and staff about the safe use and storage of oxygen. Staff would be alert to any safety concerns related to the sue or storage of oxygen, would caution the client and/or the client's representative, and would take steps to eliminate the danger and notify the RN. The RN would ensure that the client had an appropriate storage cart or stand for the oxygen cylinder or oxygen concentration and would educate the client, the client's family and client's representative about safe use and storage of oxygen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors 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	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

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03090	Continued From page 133	03090		

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 a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On November 7, 2022, at 10:11 a.m., upon entry to the facility, at the main entrance, the surveyor observed a sign that stated, "electronic monitoring equipment in use." The surveyor observed no other signs for electronic monitoring at the facility.

On November 7, 2022, at approximately 11:00 a.m., during a tour of the facility registered nurse (RN)-C stated the cameras were located throughout the building, adding none of the resident rooms had cameras.

On November 7, 2022, at 1:59 p.m., licensed assisted living director (LALD)-A stated the facility had 26 cameras, adding, "I think, but not sure if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28209	A. BUILDING: ____ B. WING ____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHVIEW GARDENS ASSISTED LIV	108 3RD STREET NORTH HACKENSACK, MN 56452

(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
03090	Continued From page 134 they all work. The feed goes into the DON's (director of nursing) office." LALD-A stated there was no audio, but the camera feed was in "real" time and recorded, LALD-A acknowledged he was not aware of the statutory language required. LALD-A commented, " I was told I needed to have a sign, so I put up a sign". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Follow-Up
Date: *11/09/22*
Time: 14:22:35
Report: 8046221164

Food and Beverage Establishment Inspection Report

Location:
Birchview Gardens Assisted Liv
108 3rd Street North
Hackensack, MN56452
Cass County, 11

Establishment Info:
ID #: 0038002
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202931472
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 previously issued on 11/08/22 have NOT been corrected.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

OBSERVED 3 BASIN SINK MIXER NOT FEEDING. CHLORINE ADDED MANUALLY.

Issued on: 11/08/22 *Comply By: 11/29/22*

2-100 Supervision

2-101.11 ** Priority 2 **

MN Rule 4626.0025 Designate a person in charge and ensure that the person in charge is present in the establishment during all hours of operation.

CFPM DOES NOT WORK ON SITE, OBSERVED MULTIPLE VIOLAITONS THAT FALL UNDER THE DUTIES OF THE PIC/CFPM.

Issued on: 11/08/22 *Comply By: 11/29/22*

No NEW orders were issued during this inspection.

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

DISH MACHINE BOOSTER HEATER HAS BEEN REPAIRED. CHEMICAL MIXER IS BEING REPLACED. TEST STRIPS FOR BOTH QUATERNARY AMMONIUM AND CHLORINE ARE NOW AVAILABLE. STRIPS WILL BE USED DAILY WHEN MAKING SANITIZER SOLUTION.

A NEW DUTY LIST IS BEING DEVELOPED, AND A DAILY TEMPERATURE LOG IS BEING

Food and Beverage Establishment Inspection Report

CREATED WITH CRITICAL LIMITS LISTED. DISH CONTACT TEMP WILL BE LOGGED DAILY.

THE FOOD SERVICE DIRECTOR IS OBTAINING A CFPM CARD.

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 8046221164 of 11/09/22.

Certified Food Protection Manager:______________________________

Certification Number: ______________ Expires: __/ /__________

Signed:__________________________________
Establishment Representative

Signed: Zach Johnson

Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us