Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery
November 13, 2023

Licensee
Crest View on 42nd
900 42nd Avenue Northeast
Columbia Heights, MN 55421

RE: Initial License Number 410726177
Health Facility Identification Number (HFID) 21871
Project Number(s) SL21871015

Dear Licensee:

On October 25, 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 October 25, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective November 13, 2023.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 30, 2023, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 25, 2023, found not corrected at the time of the follow-up survey follow-up survey and subject to a penalty assessment are as follows:

0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4 - $500.00

The details of the violations noted at the time of this follow-up survey completed on October 25, 2023, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on October 25, 2023, we identified the following violation(s):

1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1880-Storage Of Medications-144g.71 Subd. 19

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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 actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

IMPOSITION OF FINES:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated

with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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 MDH 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.

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, 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
	21871	A. BUILDING: _____ B. WING _____	R 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21871015-1 On October 23, 2023, through October 25, 2023, the Minnesota Department of Health conducted a licensing order follow-up related to correction orders issued for SL21871015-0, and the following correction orders are issued/re-issued. At the time of the survey, there were 52 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of eight residents (R3 and R23). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	{0 630}		

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{0 630}	Continued From page 2 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: R3 R3 admitted to the licensee for services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's record included an IAPP which identified that R3 was susceptible to abuse from another individual, including other vulnerable adults and that R3 was at risk of abusing other vulnerable adults, however, it lacked statements of the specific measures to be taken to minimize the risk of abuse. R23 R23 re-admitted to the licensee for services on August 4, 2023. R23's diagnoses included peripheral vascular disease, Type 2 diabetes mellitus, major depressive disorder, hypertension, and anxiety. R23's record included an IAPP which identified that R23 was susceptible to abuse from another individual, including other vulnerable adults and that R23 was at risk of abusing other vulnerable adults, however, it lacked statements of the specific measures to be taken to minimize the risk of abuse. The licensee's Individual Abuse Prevention Plan	{0 630}		

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{0 630}	Continued From page 3 policy, dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each assisted living resident and the plan would contain statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On October 25, 2023, at 11:45 a.m., director of nursing (DON)-D stated, "Our protocol is we identify the risk, put it in the IAPP and we eliminate that risk, we are literally going through them (IAPP's) all now to put in interventions." No further information was provided.	{0 630}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{0 660}		

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{0 660}	Continued From page 4 licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptom screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of three employees (unlicensed personnel (ULP)-E) with employee 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-N was hired on August 21, 2023, to perform direct care services to the licensee's residents. ULP-N's employee records included a Tuberculin Skin Test (TST)/ Mantoux Version form that read, "Nurse Administering TST: Ask employee if they have ever had a positive reaction in the past OR treated for TB." The form was marked "Yes: Do not give Mantoux". ULP-N's employee records lacked any type of previous documentation to corroborate this and lacked evidence of screening for active TB with either a two-step TST or blood test. On October 24, 2023, at 10:33 a.m., clinical administrator (CA)-H, stated, "I checked with HR and if they tell us that they have had a positive in	{0 660}		

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{0 660}	Continued From page 5 the past, then we just do a chest x-ray. That is our practice for everyone." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommend all health care professionals complete a TB screening including a symptom evaluation and a interferon gamma release assay (IGRA) or TST for those without documented prior TB disease or LTBI (latent tuberculosis infection). TB screening is defined as a process that includes a TB risk assessment, symptom evaluation, TB testing for M. tuberculosis infection (by either IGRA or TST) for health care personnel without documented evidence of prior LTBI or TB disease, and additional workup for TB disease for health care personnel with positive test results or symptoms compatible with TB disease. The licensee's TB Prevention and Control policy dated July 29, 2021, indicated the following: -screening of assisted living staff, and contracted staff and volunteers for TB. If {licensee} is assessed as medium risk, the screening and testing will be conducted annually. This screening will be performed by a registered nurse; and -maintain all reports of TB screening in the personnel files of assisted living employees and volunteers. No further information was provided.	{0 660}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}		

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{0 800}	Continued From page 6 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{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	{0 810}		

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{0 810}	Continued From page 7 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440		

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01440	Continued From page 8 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G had a hire date of July 13, 2023. The licensee's employee schedule dated October 12, 2023, through October 25, 2023, showed ULP-G had worked 2:30 p.m. to 11:00 p.m., on October 14-15, 2023. ULP-G's record lacked evidence a RN conducted direct supervision of ULP-D within 30 days of performing delegated tasks. On October 25, 2023, at 11:53 a.m., licensed assisted living director (LALD)-C stated, "It looks like it was not done, that was before [DON] started but nobody went back to ensure it got done."	01440		

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01440	Continued From page 9 The training policies provided by the licensee did not address 30-day supervision of staff. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document administration or refusal of medications according to provider orders for five of five residents (R3, R11, R13, R23, and R24). 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	{01760}		

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{01760}	Continued From page 10 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: R3 R3 admitted to the licensee for services on September 6, 2019. R3's Signed Service Plan dated October 18, 2023, indicated R3 received services to include medication administration. R3's medication administration record for October 2023 had missing charting for the following: - October 16, 2023, at 5:45 a.m., paroxetine 60 milligrams (mg), acetaminophen 1000 mg, Aspercreme Lidocaine External Cream 4 percent (%), Baclofen 5 mg, calcium carbonate 500 mg, cholecalciferol 125 micrograms (mcg), clonazepam 0.5 mg, Depakote 125 mg, fiber-lax 625 mg, Gabapentin 100 mg, lactulose 15 milliliters (ml), levothyroxine sodium 75 mcg. There was no reason written for why the medications were not given. - October 3, 5, 10,12,17, and 19, 2023, at 12:00 p.m., acetaminophen 1000 mg, Baclofen 5 mg, and Gabapentin 100 mg. There was no reason written for why the medications were not given. - October 2, 3, 4, 6, 8, 12, 13, and 17, 2023, at 7:00 p.m., acetaminophen 1000mg, Aspercreme Lidocaine External Cream 4%, Baclofen 5 mg, calcium carbonate 500 mg, clonazepam 0.5 mg, Depakote 125 mg, and Gabapentin 100 mg. There was no reason written for why the medications were not given.	{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
{01760}	Continued From page 11 R11 R11 admitted to the licensee for services on November 17, 2016. R11's Medication Assessment/Med Management Plan dated August 25, 2023, indicated R11 received medication administration services. R11's medication administration record for October 2023 had missing charting for the following: - October 2, and 5, 2023, at 8:00 a.m., cholecalciferol 50 mg. There was no reason written for why the medications were not given. - October 2, and 5, 2023, at 9:30 a.m., furosemide 40 mg. There was no reason written for why the medications were not given. - October 2, and 5, 2023, at 11:00 a.m., Systane solution 0.4-0.3%. There was no reason written for why the medications were not given. R13 R13 admitted to the licensee for services on December 31, 2020. R13 Medication Assessment/Med Management Plan dated August 30, 2023, indicated R13 received medication administration services. R13's medication administration record for October 2023 had missing charting for the following: -October 11, and 21, 2023, at 12:00 p.m., acetaminophen 1000 mg, albuterol sulfate 108 mcg, Capsaicin cream 0.025 %, hydralazine hydochloride 50 mg, Mucinex 600 mg, propylene glycol solution 0.6%, and Senna-S 8.6 mg-50 mg. There was no reason written for why the medications were not given. -October 11, 2023, at 4:00 p.m., albuterol sulfate	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	R 10/25/2023

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{01760}	Continued From page 12 108 mcg, and Capsaicin cream 0.025 %. There was no reason written for why the medications were not given. -October 11, 2023, at 6:00 p.m., propylene glycol solution 0.6%. There was no reason written for why the medications were not given. -October 11, 2023, at 8:00 p.m., acetaminophen 1000 mg, albuterol sulfate 108 mcg, Capsaicin cream 0.025 %, fluticasone propionate 50 mcg, hydralazine hydrochloride 50 mg, montelukast sodium 10 mg, Mucinex 600 mg and Senna-S 8.6 mg-50 mg. There was no reason written for why the medications were not given. R23 R23 admitted to the licensee for services on August 4, 2023. R23 Signed Service Plan dated August 10, 2023, indicated R23 received services to include medication administration. R23's medication administration record for October 2023 had missing charting for the following: - October 18, 2023, at 8:00 p.m., trazadone hydrochloride 50 mg, Ferrous sulfate 325 mg, Lantus Solostar100 unit/ml inject 24 units, metformin hydrochloride 1000 mg, and Pregabalin 150 mg. There was no reason written for why the medications were not given. - October 19, 2023, at 12:00 p.m., Pregabalin 150 mg. There was no reason written for why the medications were not given. R24 R24 admitted to the licensee for services on March 8, 2018. R24 Signed Service Plan dated October 18,	{01760}		

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{01760}	Continued From page 13 2023, indicated R24 received services to include medication administration. R24's medication administration record for October 2023 had missing charting for the following: -October 5, and 22, 2023, at 10:30 a.m., Lexapro 10 mg, Abilify 10 mg, calcium carbonate one tablet, Farxiga 10 mg, glipizide 5 mg, hypromellose solution 0.5%, Lyrica 100 mg, Metamucil 6.8 grams, and metformin hydrochloride 500 mg. There was no reason written for why the medications were not given. On October 25, 2023, at 11:49 a.m., director of nursing (DON)-D stated, "I have to go into EMAR (electronic medication administration record) and POC (plan of care) each day to look for medication errors, or missed documentation, I do this on each shift and tell them to fix it, because it should be documented, because if it's not documented it didn't get done. I don't know why they are not documenting it." The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, read, "Staff will document each task immediately after that task has been performed." No further information was provided.	{01760}		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access to the nurse's medication cart located in the nurse's office that contained all the overflow medications for all residents in the building. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 24, 2023, at 2:10 p.m., the surveyor observed the nursing office medication cart to be unlocked and unattended. The nurse's medication cart was located in the unlocked nurse's office that had the door propped open. The nurse's medication cart contained all the overflow medications for all residents in the building. There were three unlicensed personnel working in the connected offices. On October 24, 2023, at 2:20 p.m., licensed practical nurse (LPN)-A stated, "I always lock the cart when I leave, but I needed to make a break for the bathroom and had to rush out." On October 25, 2023, at 11:49 a.m., director of	01880		

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01880	Continued From page 15 nursing (DON)-D stated, "All meds should be secured they need to push in the button and lock the cart when they leave them." The licensee's Storage of Medications policy dated, August 1, 2021, read, "When secured storage of the medication is necessary, The RN (registered nurse) will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
{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 ensure all medications were properly labeled and failed to discard expired medications. 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	{01890}		

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{01890}	Continued From page 16 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 October 24, 2023, at 2:10 p.m., the surveyor observed the nursing office medication cart that was accessible to the unlicensed personnel (ULP) for medication administration to residents, and observed the following unlabeled medications: UNLABELED - Refresh eye drops containing an unknown amount of solution; and - Ketoconazole 2 percent cream containing an unknown amount of cream. On October 24, 2023, at 1:30 p.m., the surveyor observed the second-floor medication cart that was accessible to the ULP for medication administration to residents, and observed the following expired medications: EXPIRED - R26's albuterol sulfate 0.63 mg. On October 24, 2023, at 2:20 p.m. licensed practical nurse (LPN)-A stated, "I need to destroy those, so they are up there to be destroyed, we destroy meds on Fridays." On October 25, 2023, at 11:35 a.m., ULP-K stated, "I report all expired meds to the nurse immediately, I take it out of the cart and give it to the nurse. I didn't realize those are in there because they haven't been used in forever."	{01890}		

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{01890}	Continued From page 17 On October 25, 2023, at 11:49 a.m., director of nursing (DON)-D stated, "Any expired or discontinued meds they (staff) should bring to the attention of the LPN so they can order new meds. LPN should remove them from the cart and they will destroy them on Friday's and reorder." The licensee's Disposition or Disposal of Medication policy, dated August 1, 2021, indicated the licensee would destroy unused or discontinued medications and document the date it was destroyed, quantity, name of drug, prescription number, signature of person destroying the medications, and signature of witness to the destruction. The destruction record must be recorded and maintained in the resident's record for two years. No further information was provided.	{01890}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	{01940}		

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{01940}	Continued From page 18 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of four residents (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R11 admitted to the licensee for services on November 17, 2016. R11's diagnoses included type 2 diabetes mellitus, anemia, gastro-esophageal reflux	{01940}		

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{01940}	Continued From page 19 disease, and chronic venous hypertension. R11's medication administration record dated October 1, 2023, through October 31, 2023, included Ace Wrap to both lower extremities, from ankle to knee daily. One time a day for edema/wound and blood sugar monitoring, "ask the resident what her blood sugar is & document in PCC" (Point Click Care, an electronic charting system). R11's treatment plan dated August 25, 2023, lacked the following required content for blood sugar monitoring and ace wrap application: - resident specific instructions related to the treatments/therapy administration; - process for notifying an RN or appropriate licensed health professional when an issue or concern arises; and - resident specific requirements related to documentation of treatments/therapy received, verification that it was administered as prescribed and monitoring to prevent possible complications and/or adverse reactions. On October 25, 2023, at 11:38 a.m., unlicensed personnel (ULP)-K stated, "We are trained to contact the nurse if it's (blood glucose) over 350 or under 50. It's just standard practice." On October 25, 2023, at 11:49 a.m., director of nursing (DON)-D stated, "The order itself should read what the parameters are but it is not in here (the electronic charting system) on any of them I am looking at (residents with blood glucose monitoring), so the aides won't see it." The licensee's Treatment & Therapy Management Plan dated September 1, 2023 indicated the individualized treatment plan would	{01940}		

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{01940}	Continued From page 20 include the above content. No further information was provided	{01940}		
{01950} SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident treatment and documented those instructions in the resident's record for one of three residents (R11). 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	{01950}		

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{01950}	Continued From page 21 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: R11 admitted to the licensee for services on November 17, 2016. R11's diagnoses included type 2 diabetes mellitus, anemia, gastro-esophageal reflux disease, and chronic venous hypertension. R11's medication administration record (MAR) dated October 1, 2023, through October 31, 2023, included blood sugar monitoring, "ask the resident what her blood sugar is & document in PCC (point click care, an electronic charting system). R11's MAR dated October 1, 2023, through October 31, 2023, directed for staff to ask resident what their blood glucose level was and document two times a day (11:00 a.m., and 4:00 p.m.). R11's blood glucose monitoring documentation, indicated blood glucose checks had been completed two times daily with staff having documented results ranging from 140 to 350 milligrams (mg)/deciliter (dL). R11's MAR did not indicate any instructions for what staff should do for a low or high blood glucose reading. R11's record lacked documentation of specific, written instructions and evidence the instructions were communicated with the unlicensed personnel (ULP) about the individual needs of the resident.	{01950}		

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{01950}	Continued From page 22 On October 24, 2023, at 11:07 a.m., ULP-L stated, "Oh if it's low or she feels funny we let the nurses know. She tells us." On October 25, 2023, at 11:38 a.m., ULP-K stated, "We are trained to contact the nurse if it's (blood glucose) over 350 or under 50. It's just standard practice." On October 25, 2023, at 11:49 a.m., director of nursing (DON)-D verified R11's records lacked specific, written instructions for the procedures, including when the registered nurse should be notified. DON-D stated, "The order itself should read what the parameters are but it is not in here (the electronic charting system) on any of them (residents with blood glucose monitoring) I am looking at, so the aides won't see it." The licensee's Treatment & Therapy Management Plan policy dated August 1, 2023, read, "Licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided; b. Documentation of specific resident instructions relating to the treatments or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; e. Any resident specific requirements relating to documentation of treatment and therapy received; and	{01950}		

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{01950}	Continued From page 23 f. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." No further information provided.	{01950}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered
August 8, 2023

Licensee
Crest View on 42nd
900 42nd Avenue Northeast
Columbia Heights, MN 55421

RE: Conditional License Number 410726177
Health Facility Identification Number (HFID) 21871
Project Number(s) SL21871015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 30, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **November 6, 2023.**

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

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $12,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply $3,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144G.**

The correction order documentation should include the following:

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

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

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Crest View on 42nd 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 survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Crest View on 42nd 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:** Crest View on 42nd will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Crest View on 42nd must provide MDH:

    i. A list of the names and birthdates of any individuals Crest View on 42nd 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:** Crest View on 42nd will contract with an RN to provide consultation concerning all resident(s) to whom Crest View on 42nd provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Crest View on 42nd. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's</u>

judgement or at the discretion of MDH. The RN must not have any affiliation with Crest View on 42nd and MDH must review the RN's credentials and approve the selection. Crest View on 42nd is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Crest View on 42nd in an effort to help Crest View on 42nd 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. Crest View on 42nd 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 Crest View on 42nd and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Survey 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 orders;
   ii. Observations of staff delivering assisted living services and the level of competency observed;
   iii. Conversations with residents and family members about satisfaction with assisted living services;
   iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
   v. Overall impressions about the quality of the assisted living services delivered;
   vi. Overall impressions about the dignity with which the residents and their family members are treated;
   vii. Concerns; and
   viii. Any other information requested by MDH or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Crest View on 42nd to correct the violations cited during the survey as well as to determine the overall practice of Crest View on 42nd in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Crest View on 42nd 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 Crest View on 42nd is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Crest View on 42nd is in substantial compliance on the follow up survey, MDH will remove the conditions from Crest View on 42nd's assisted living facility license, and Crest View on 42nd will correct violations identified during the survey to come into substantial compliance. If MDH determines Crest View on 42nd is not in substantial compliance, MDH may take additional enforcement action against Crest View on 42nd, 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.

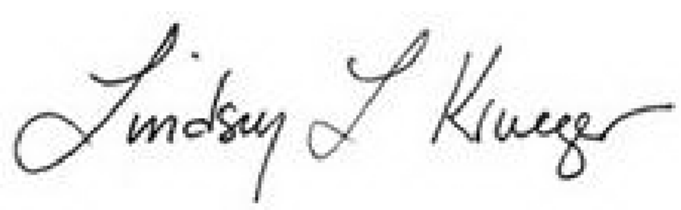
REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and 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 the letter and state form with your organization's Governing Body.

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

Sincerely,



Lindsey L. Krueger, RN, BS, MA
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
	21871	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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****** AMENDED ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL21871015-0 On June 26, 2023, through June 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 54 active residents; 52 of whom received services under the Assisted Living with Dementia Care license. On August 8, 2023, the enclosed correction orders were issued to the facility. On August 9, 2023, the initial comments of the correction orders were amended to change the outcome related to the removal of immediacy for tag identification 0830. No change was made to the content of tag 0830 or any other correction order. The time period for correction is continued from the original issuance date. An immediate correction order was identified on June 27, 2023, issued for SL21871015-0, tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 identification 2310. Immediate correction orders were identified on June 27, 2023, issued for SL21871015-0, tag identification 0720 and 0830. Immediate correction orders were identified on June 28, 2023, issued for SL21871015-0, tag identification 1290 and 1750. On June 28, 2023, the immediacy of correction order 0720 was removed, however non-compliance remained at a level two widespread violation. On June 29, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained at a level three widespread violation. On June 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three widespread violation. On June 30, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three widespread violation. On June 30, 2023, the immediacy of correction order 1750 was removed, however non-compliance remained at a level three widespread violation.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 2 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 3 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at approximately 10:53 a.m., licensed assisted living director (LALD)-C stated	0 250		

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0 250	Continued From page 4 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. 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	0 250		

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0 250	Continued From page 5 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	0 250		

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0 250	Continued From page 6 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 six was electronically signed by LALD-C on November 18, 2022. The licensee had an assisted living license issued on March 1, 2023, with an expiration date of February 29, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - implementation of the assisted living bill of	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 250	Continued From page 7 rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On June 29, 2023, at approximately 1:14 p.m., registered nurse (RN)-D confirmed the licensee provided Assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0470, 0480, 0485, 0510, 0550, 0630, 0650, 0660, 0680, 0720, 0730, 0800, 0810, 0830, 0950, 0970, 1060, 1290, 1470, 1500, 1530, 1540, 1620, 1640, 1700, 1710, 1730, 1750, 1760, 1820, 1830, 1890, 1910, 1940, 1950, 2040, 2070, 2110, 2170, 2310, and 2480 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 8 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content to one of one resident (R4) with records reviewed. 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:	0 430		

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0 430	Continued From page 9 R4 R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R4's signed service plan dated October 16, 2020, indicated R4 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and behavior monitoring/redirecting. On June 27, 2023, from 7:20 a.m., through 7:48 a.m., surveyor observed R4 receive medication administration and AM cares. On June 29, 2023, at 1:00 p.m., licensed assisted living director (LALD)-C stated they were unable to locate a UDALSA acknowledgement form for R4, and R4 and/or their representative would have signed indicating they had received it. On June 29, 2023, at 1:06 p.m. LALD-C stated, "Anybody that moved in after 144G [August 1, 2021] went into effect would have gotten the new contracts and UDALSA, but anyone who moved in prior to that would not have gotten a new one." The licensee's Uniform Checklist Disclosure of Services policy dated August 1, 2021, indicated the licensee would "Provide UDALSA to residents prior to move-in, upon move-in, or if any changes to the UDALSA are made" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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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
0 470	Continued From page 10	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location, potentially affecting the licensee's 54 residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a	0 470		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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0 470	Continued From page 11 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: On June 26, 2023, at 11:15 a.m., the surveyor observed the common areas shared by residents, staff, and visitors lacked the required posting of a daily staffing schedule. On June 26, 2023, at 11:18 a.m., licensed assisted living director (LALD)-C stated a posting of the daily staffing schedule should be located in the common areas. LALD-C showed the surveyor where the schedule was hung on the wall behind the reception desk. The schedule was on a clipboard and covered with a paper that read staff schedule. LALD-C stated the licensee's staff schedule was usually out where residents could see it. The staffing schedule remained covered and hung on the wall behind the reception desk for the duration of the survey. The licensee's Staffing, Direct-Care Staffing Plan & Daily schedule policy dated August 1, 2021, read, "The daily work schedule will be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated June 28, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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:	0 485		

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0 485	Continued From page 13 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. This had the potential to affect all memory care residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 485		

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0 485	Continued From page 14 On June 26, 2023, at 10:53 a.m., during entrance conference, licensed assisted living director (LALD)-C stated the licensee provided three meals per day, served per Minnesota (MN) Food Code. On June 26, 2023, at 12:08 p.m., LALD-C provided the surveyor with an undated menu titled Crestview on 42nd week 3. LALD-C stated that was the current weeks menu. The menu showed that on Wednesday June 26, 2023, the residents would be offered the following; -continental [breakfast] - oatmeal/cold cereal, toast/bagel/assorted rolls. -lunch - chicken salad crossaint, potato chips, apple slices. -alternate - sandwhich of the day, soup of the day. -dinner - roasted turkey, parsley potato, mixed vegetable, fruit cocktail. LALD-C stated, "That is the only menu, it shows they can choose the soup of the day or sometimes a salad, otherwise what is listed on the menu is what we offer." The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the USDA guidelines. On June 27, 2023, at 6:52 a.m., surveyor observed unlincensed personnel offer R3 a Danish, cold cereal, and juice or tea for breakfast. No other breakfast options were available. On June 27, 2023, at 6:59 a.m., unlicensed personnel (ULP)-B stated, "This is what they send us, and we feed them what they send. They don't send fruit; I can't offer fruit." On June 27, 2023, at 11:00 a.m., surveyor observed residents eating sloppy joes, French	0 485		

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0 485	Continued From page 15 fries and a pickle. Surveyor did not observe any fruit or vegetable with the meal. On June 27, 2023, at 4:40 p.m., R10 stated she could not digest meat, so she asked for salads but did not get them. The USDA My Plate: A Guide dated September 1, 2022, indicates half of food plates should include fruits and vegetables. Additionally, it indicated the fruit group includes 100% fruit juices, however, specified at least half of the recommended amount of fruit eaten should come from whole fruit, rather than 100% fruit juice. The licensee's undated Meal Agreement reads, "The facility must offer at least three nutritious meals daily with snacks available seven days per week, in accordance with the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables, and meal substitutions must be of similar nutritional value if a resident refuses a food that is served." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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	0 510		

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0 510	Continued From page 16 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 establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one unlicensed personnel ((ULP)-F) observed to provide personal cares and medication administration for multiple residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on June 27, 2023, between 11:30 a.m. and 12:12 p.m., ULP-F was setting up medications for R21 and without wearing gloves, she used her hands to pour a medication from a medication bottle and placed it into the small plastic medication cup. After medication administration with R21, ULP-F did not wash her hands. She met R8 at the front entry of the facility and gave the electronic device to R8 to hold while ULP-F propelled R8 back to her room. ULP-F	0 510		

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0 510	Continued From page 17 performed no hand hygiene before transferring R8 from wheelchair to recliner. ULP-F proceeded to R8's kitchen to set up her medications without washing hands. After medication administration, and without washing hands, ULP-F went to R22's room, donned (applied gloves) and assisted R22 with toileting. R8 requested privacy so surveyor waited in the kitchen of R8's apartment. ULP-F came out of bathroom with R8 and proceeded to set up medications in R8's kitchen area. Surveyor did not observe handwashing, but it was unknown if hand hygiene was performed within the bathroom. After ULP-F completed medication administration with R8, she proceeded to R15's room without hand hygiene. ULP-F set up R15's medication and gave it to R15, then left the room without hand hygiene. During interview on June 27, 2023, at 12:20 p.m., surveyor asked when she was trained to complete hand hygiene. ULP-F stated, "thank you for reminding me I need to wash my hands." ULP-F's undated training record included competencies on hand hygiene and hand washing. During interview on June 29, 2023, at 1:12 p.m., registered nurse (RN)-D stated infection control training should be done at new hire orientation, and staff should be signed off by an RN. For hand hygiene, staff can hand sanitize three times before they need to wash their hands. Hand washing should be performed between cares, and after doffing (removing) gloves. RN-D also stated medications should never touch bare hands, medications should be poured into the cap of the medication bottle, then poured into the medication cup. Lastly, staff needed to administer medications with their hands, they must wear	0 510		

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0 510	Continued From page 18 gloves. The licensee's undated Infection Control Policy indicated they would follow standard and transmission-based precautions to be followed to prevent the spread of infections: -hand hygiene to be followed by staff with direct care, handling resident care equipment and the environment; -selection and use of personal protective equipment (PPE) for residents and/or staff; and -PPE use appropriate to the infection or outbreak. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated July 29, 2021, effective August 1, 2021, indicated the RN would instruct staff on infection control techniques that must be followed when administering medications, treatment and therapy including hand washing and the use of gloves when appropriate. 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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	0 550		

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0 550	Continued From page 19 for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on June 26, 2023, at 12:00 p.m., surveyor observed a Record of Grievance/Complaint posting did not include the contact information such as name, telephone number, and email contact information for the individual responsible for handling resident grievances. On June 29, 2023, at 3:03 p.m., registered nurse (RN)-D stated the grievance posting should have included the community contact, corporate	0 550		

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0 550	Continued From page 20 contact, and administrators contact information. The licensee's Complaint Policy and Procedure effective August 1, 2021, indicated the written notice all residents receive would have the name and contact information of the person representing the facility designated to handle and resolve complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of four residents (R1, R3).	0 630		

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0 630	Continued From page 21 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 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: R1 R1 admitted to the licensee for services on August 2, 2021. R1's diagnoses included alcohol abuse, history of depression, atrial fibrillation, and unspecified protein-calorie malnutrition. R1's IAPP dated June 2, 2022, indicated R1 did not have areas of vulnerability in behaviors posing a risk to self, alcohol abuse, and smoking. R1's record included progress notes as follows: -On March 9, 2023, at 4:05 p.m., registered nurse (RN)-M documented R1 was smoking in his room on multiple occasions, maintenance staff reported to RN-M that he walked into R1's room and witnessed him actively smoking on his bed; -March 24, 2023, at 3:16 p.m., RN-M documented R1 continued to smoke cigarettes in his room and burn incense. R1 was given an "infraction notice" again today; -March 29, 2023, at 11:26 a.m., RN-M documented that R1 was given a lease violation notice for smoking inside, burning incense, and propping main door open; -April 5, 2023, at 1:05 p.m., RN-M documented that R1 was given another lease violation letter	0 630		

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0 630	Continued From page 22 due to smoking inside his room; -April 12, 2023, at 2:11 p.m., RN-M documented R1 was not witnessed smoking in his room that shift but RN-M could smell lingering odor. RN-M re-educated R1 on the danger to other residents as well as importance of following his no smoking lease agreement. R1 became angry on approach and denied smoking inside; -April 17, 2023, at 8:14 a.m., LPN-J documented they walked by R1's room and R1 was smoking a cigarette; LPN-J told R1 he wasn't supposed to be smoking and asked to put the cigarette out, which he did; -April 18, 2023, at 7:18 a.m., LPN-J documented unlicensed personnel (ULP) reported to them that R1 was smoking in his apartment that morning; -April 20, 2023, at 1:12 p.m., RN-M documented R's1 apartment produced a strong cigarette smoke smell, so an air purifier was moved from the apartment kitchen to R1's room; -April 25, 2023, at 10:14 a.m., LPN-J documented R1 was smoking in his room and was putting it out as LPN-J entered his room; and -April May 8, 2023, at 9:57 a.m., LPN-A documented LPN-C received a call from ULP reporting R1 hit ULP in the face and grabbed her arm when she asked R1 to smoke in the designated area because residents were complaining. Police were called and a report was filed. During interview on June 27, 2023, at 1:21 p.m., RN-D stated the IAPP should have addressed the smoking, alcohol abuse, and behaviors. R3 R3 admitted to the licensee for services on September 6, 2019. R3's diagnoses included epilepsy, multiple	0 630		

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0 630	Continued From page 23 sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's record included an IAPP which reviewed the resident's susceptibility to abuse by another individual, including other vulnerable adults and the resident's risk of abusing other vulnerable adults, however, it lacked statements of the specific measures to be taken to minimize the risk of abuse. On June 28, 2023, at 11:20 a.m., licensed assisted living director (LALD)-C stated, "I took a quick look at the IAPP, and I didn't see it, so I am guessing that what you see is all that's there. I'm not sure why its missing information." The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each assisted living resident and the plan would contain statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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
0 650	Continued From page 24 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, and licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B	0 650		

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0 650	Continued From page 25 ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-B's employee record lacked the following documentation of required competency training completed by a registered nurse (RN): -administering medications or treatments as required. On June 27, 2023, at 7:58 a.m., ULP-B stated, "I was trained when I was hired but that was over 20 years ago, so I don't recall what all we did. I don't remember who all trained me, but I was trained to pass medications. I follow the rights and I do all the checks." LPN-A During interview on June 29, 2023, at 8:15 a.m., licensed assisted living director (LALD)-C stated LPN-A was hired May of 2022 to work part-time. Prior to that, LPN-A worked for different facility under the umbrella of the same parent company. LPN-A's employee record lacked documentation of orientation training in the following: -overview of Assisted Living statutes; -review of provider's policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -Assisted Living bill of rights; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; -principles of person-centered planning/service	0 650		

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0 650	Continued From page 26 delivery; and -orientation to each specific resident and services provided [144G.63 Subd. 3]. On June 28, 2023, at 12:26 p.m., LALD-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 28, 2023, at 3:35 p.m., LALD-C stated, "Let's just say I can't find her [ULP-B] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy effective date August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 27 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, baseline screening and TB training for two of two employees (unlicensed personnel (ULP)-B) and (licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-C provided the facility TB risk assessment. The TB	0 660		

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0 660	Continued From page 28 risk assessment dated April 3, 2023, indicated the licensee was low risk. ULP-B had a start date of December 4, 2002. ULP-B's employee record lacked evidence of the following: -baseline TB screening; and -TB training. LPN-A had a start date of December 9, 2005. LPN-A's employee record lacked evidence of the following: -baseline TB screening. During interview on June 29, 2023, at 3:12 p.m., registered nurse (RN)-D stated, "Mantoux needs to be done and you need to do baseline screening from date of new hire and they have to get either a 2 step Mantoux or a chest X-ray or QuantiFERON and then annual screening needs to be done and they should be keeping the records, but LALD-C is having a hard time finding the records because they just don't have them. Also, the annual TB risk assessment determines risk level based on county transmission and then the screening forms themselves should be completed annually and kept in the employee file." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's TB Prevention and Control policy dated July 29, 2021, indicated the following: -education of assisted living staff and contracted staff volunteers regarding TB signs and	0 660		

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0 660	Continued From page 29 symptoms, infection control plan and other communicable diseases; -screening of assisted living staff, and contracted staff and volunteers for TB. If {licensee} is assessed as medium risk, the screening and testing will be conducted annually. This screening will be performed by a registered nurse; and -maintain all reports of TB screening in the personnel files of assisted living employees and volunteers. The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy dated July 29, 2021, indicated all employees must complete orientation to assisted living facility licensing requirements which included TB prevention and control. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 30 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Disaster Plan Policy and Procedure did not include the following required content: - community risk assessment with documentation; - categorize the various probable risks/hazards by	0 680		

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0 680	Continued From page 31 likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); and -missing resident plan; - develop and implement EP policies/procedures and review/update annually; - subsistence needs for staff and residents during emergency situation; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; and - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; and - volunteers - communication plan must include contact information for: - MN Office of Ombudsman for LTC; and - other sources of assistance -Communication plan must include: -primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management	0 680		

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0 680	Continued From page 32 agencies - communication plan must include: - means to provide information about facility occupancy/needs; -Communication plan must include all of the following: -means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; -Communication plan must include all of the following: -method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives The licensee's undated Disaster Plan Policy and Procedure indicated the licensee would provide guidelines for actions to those individuals responsible for the safety of the residents, tenants, staff, the visiting public and the facility itself. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon	0 720		

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0 720	Continued From page 33 request. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that resident records were readily available for employees authorized to access the records during medication administration. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 entrance conference on June 26, 2023, at approximately 10:30 a.m., licensed practical nurse (LPN)-A stated the licensee provided medication administration to the residents. The licensee utilized an electronic device to access the medication administration record (MAR) for each staff person administering medications. LPN-C also indicated each resident's medications were stored within their apartment in a locked box inside of a cabinet. During observation on June 27, 2023, at 10:15 a.m., unlicensed personnel (ULP)-G entered a resident's room and had an electronic device without access to the MAR due to internet issues. ULP-G stated she went downstairs to check the MAR before coming upstairs to set up the medication. ULP-G administered the medication	0 720	On June 28, 2023, the immediacy of correction order 0720 was removed, however non-compliance remained at a level two widespread violation.	

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0 720	Continued From page 34 and left the room. During observation on June 27, 2023, between 11:30 a.m. and 12:12 p.m., ULP-F set up and administered medications for four residents and three of those four residents' apartments did not have internet access. ULP-F proceeded to set up medications without access to the MAR for three of those residents. During interview on June 27, 2023, at 11:30 a.m., ULP-F stated at the beginning of every shift, she checks the MAR located in the nursing office for any changes in resident medications. She stated sometimes she would write them down on paper. ULP-F also stated she had been working with these residents for a very long time and she "knows them." During interview on June 27, 2023, at 2:09 p.m., licensed assisted living director (LALD)-C stated the internet issue was brought to her attention about four months ago and she was currently working with information technology (IT) to fix it. During interview on June 27, 2023, at 2:10 p.m., ULP-F stated the internet had always been "spotty," but it became a real issue about six months ago. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, stated unlicensed personnel would complete procedure for checking the {resident's} MAR and medication profile. Additionally, medications must be administered according to the "6 rights:" -right person, -right medication, treatment or therapy, -right time,	0 720		

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0 720	Continued From page 35 -right route, -right dose, and -right chart/record to document that the medication, treatment and therapy was given No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 720		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730		

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0 730	Continued From page 36 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of two discharged residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 admitted for services on September 20, 2019, and discharged to a transitional care unit (TCU)	0 730		

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0 730	Continued From page 37 on January 24, 2023. R2's record lacked a discharge summary. On June 27, 2023, at 1:15 p.m., registered nurse (RN)-D stated, "looking through the past discharges the previous nurse was not doing actual discharge summaries for anyone." The licensee's Discharge Summary policy, dated August 1, 2021 indicated a discharge summary would be written by the time of discharge and would include if applicable, the diagnosis, courses of illness, allergies, treatments, therapies, pertinent lab results, pertinent radiology results, pertinent consultation results, and final summary of the resident's status including baseline and current mental, behavioral and functional status. No further information provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 38 Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45 a.m. During the tour, survey staff observed the following: -The memory care courtyard gate was blocked from the outside by a parked white vehicle preventing proper exiting to a public way. The gate partially opened from the inside but failed to open completely due to the vehicle obstruction of the gate for exiting. The DOM-I and M-K asked the staff to relocate the vehicle. -The memory care courtyard walkways had shrubs/landscapes obstructing the walkways to the public way. The finding was evident as the exit doors inside of the building showed signs to exit or evacuate into the courtyard. Survey staff discussed with the DOM-I that all exit discharge walks and exterior walkways serving marked exit	0 800		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

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0 800	Continued From page 39 doors through the courtyards must be continuously maintained (and seasons) for safe means of egress to the roadway during an emergency. -A large tree limb was observed overhanging the walkways located between the tree and the roof gutter in the courtyard and poses a safety concern of falling onto resident(s). -The memory care laundry room had plumbing fixtures that were no longer used (abandoned) but not properly disconnected or capped to prevent sewer gas entry into the building environment. The DOM-I confirmed and explained the plumbing fixtures were no longer used for many years. -The patio near the dining room had uneven concrete pad surfaces (over ½ inch) creating tripping and unsafe resident use of the patio as residents shuffle when walking. In addition, the dining room had an exit sign that discharged into the patio during an emergency and must be maintained for safe means of egress to the roadway. -Obstructions in the means of passageway and egress were observed in the memory care corridor near room 121 with tables/chairs placement, storage of mobility scooter in the corridor near room 321, and storage on the 3rd-floor stairway refuge area (located between rooms 318/320). -The back building sidewalk/walkway linking to the dining room patio had wood-constructed guardrails that were not maintained as the wood guardrails were not secured and worn out. -The sidewalks in front of the building connecting to the public way were damaged and had uneven surfaces ranging from 1 to 2 inches in size preventing safe means of egress to the roadway. In addition, the uneven and broken surfaces create safety concerns for wheelchair residents.	0 800		

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0 800	Continued From page 40 -The 1st-floor kitchen exit door hardware was not maintained as required for proper egress, failed to latch when closed, and the door handle when turned in the downward position to exit failed to open. Upon further investigation, the door handle only opened the door in the upward position when survey staff attempted to open it again. Survey staff explained to the DOM-I that the hardware for the door must function in a manner that special knowledge must not be necessary or required for safe egress. -The fire-rated door for the laundry room (3rd floor) failed to positively latch when closed which compromised the fire safety of the corridor. -The fire-rated stairway door near the chapel area failed to positively latch when closed to properly protect and maintain the integrity of the vertical stairway enclosure in the means of egress. -The room carpet flooring inside resident rooms 203, 212E, and 212W were soiled and stained. -Unlabeled multi-adapter was improperly used in resident apartment room 216 with medical equipment (oxygen) plugged into the adapter. Survey staff explained to the DOM-I and the M-K that medical equipment must directly be plugged into a dedicated power outlet. In addition, the use of unlisted and unlabeled extension cords/adapters poses a potential electrical fire hazard from overloading the electrical circuits and is a safety concern to residents. Extension cords must be listed and labeled to UL 817. Extension cords must be listed and labeled to UL 817. Multi-plug adapters must be listed to UL 498A. -Inside the common living area in resident room 301 near 301W), survey staff observed boxes and personal items on the floor restricting an adequate and proper egress path exit the apartment door for safe egress during an emergency resident 301W. -Smoke alarms were not secured to the ceiling	0 800		

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0 800	Continued From page 41 brackets and were observed hanging from the ceiling in resident rooms 103, 115, and 312. All listed findings and/or observations were visually and/or verbally verified by the DOM-I and the M-K accompanying the tour. On June 29, 2023, at approximately 2:15 p.m., during the exit interview, the LALD-C, the DOM-I, and the M-K acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 42 (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 observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff and residents on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. 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 June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45	0 810		

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0 810	Continued From page 43 a.m. On June 29, 2023, at approximately 1:15 p.m., the LALD-C and the DOM-I provided survey staff with the available facility fire safety and evacuation plan and related documentation for review. At approximately 2:00 p.m., document review and interview with the LALD-C, the DOM-I, and the M-K indicated the following: -Document review indicated that the facility's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique resident situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation, and must be addressed in the fire safety and evacuation plan documentation. -Document review indicated that the fire safety and evacuation plan lacked fire protection procedures for residents. -Document review indicated that the licensee lacks a record of employee training specifically on the fire safety and evacuation plan. The minimum required annual employee training must be twice a year for fire safety and evacuation after new employee orientation. Survey staff received employee training records on fire safety and evacuation plan for December 2022 as part of the licensee's annual emergency preparedness training. No other record was available or provided for review. -Document review indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper	0 810		

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0 810	Continued From page 44 actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During the interview, the LALD-C indicated they had no records to support the training. -Record review indicated the licensee failed to perform the minimum required frequency of evacuation fire drills. Three fire evacuation drill records were provided for review, two ddrills were performed in 2022 (9/30/2022 1:40 p.m. and 11/9/2022 2:00 a.m.), and one drill in 2023 (6/26/2023 6:45 p.m.). Survey staff explained that evacuation drills must be performed twice per year per shift with at least one evacuation drill every other month frequency. During the interview, the LALD-C and the DOM-I verified that the fire safety and evacuation plan for the facility lacked these provisions. On June 29, 2023, at approximately 2:15 p.m., during the exit interview, the LALD-C, the DOM-I, and the M-K acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by:	0 830		

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0 830	Continued From page 45 Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). 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 the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at 10:00 a.m., the surveyor entered the second floor and smelled a strong cigarette smoke odor coming from apartment 212 that infiltrated the entire second floor hallway. R1 R1 admitted to the facility on August 2, 2021. R1's diagnoses included alcohol abuse, atrial fibrillation, and unspecified protein-calorie malnutrition. R1's Task List Report dated June 27, 2023, indicated R1 received medication administration by unlicensed personnel (ULP) and twice a day safety checks. R1's last comprehensive assessment dated June 2, 2022, indicated under smoking assessment, that R1 had the ability to smoke without causing burns or injury, and no interventions were needed. R1's smoking assessment also indicated	0 830	On June 29, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained at a level three widespread violation.	

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0 830	Continued From page 46 that staff were to do safety checks with resident on each shift due to poor decision making while intoxicated. During observation on June 27, 2023, at 10:30 a.m., surveyor entered R1's apartment which is shared with another resident (common kitchen and bathroom). R1 was sitting on his/her bed and surveyor noted the only window in the bedroom opened approximately 9 inches. Surveyor observed a trash can near the bed with ashes and numerous discarded cigarette butts. Surveyor asked R1 if s/he smoked in the room and R1 said "sometimes." R1 then became agitated and asked surveyor to drop the subject and stated s/he was going to go outside and smoke. R1 then left the apartment. Throughout the survey, numerous staff and residents complained about R1's smoking to the surveyors. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws.	0 830		

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0 830	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 830		
0 950 SS=C	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:	0 950		

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0 950	Continued From page 48 Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for two of four residents (R3, R4). 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: R3 R3's Resident Agreement was signed on September 6, 2019. R3's Resident Agreement on page 2 of 15 read, -Your Designated Representative. You have designated the person or persons listed as Your Designated Representative on Page 2 of the Summary, if any, to be involved on Your behalf with respect to this Agreement, and has presented Us with documentation about authority, a copy of which is attached. The duties and obligations of Your Designated Representative are to assist You in fulfilling Your financial obligations under this Agreement in full and on time, to assist You to comply with the terms of this Agreement in other respects, and to otherwise assist You while you are a resident at [licensee]. R4 R4's Resident Agreement was signed on March 8, 2012. R4's Resident Agreement on page one read, IF	0 950		

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0 950	Continued From page 49 APPLICABLE: You have designated XXX as your Designated Representative to assist you with any matters related to this Residency Agreement. R3 and R4's Resident Agreement lacked the designate a representative verbatim "right to designate a representative for certain purposes" notice. On June 29, 2023, at 1:06 p.m., licensed assisted living director (LALD)-C stated, "Anybody that moved in after 144G [regulations] went into effect would have gotten the new contracts and Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), but anyone who moved in prior to that would not have gotten a new one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	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 contract did not include language waiving the	0 970		

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0 970	Continued From page 50 licensee'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 or has potential to affect a large portion or all of the residents). The findings include: R3 R3's signed assisted living contract read, -Your Personal Property; No Liability of Management. "Management has no responsibility to You or any third party for any personal property placed in the Apartment or in any other location within Crest View on 42nd by You or the owner of such personal property. Management is not responsible to You or any third party for loss of any personal property by theft or any other cause. You assume all risk for harm to or loss of any of Your personal property, and release, indemnify, defend, and hold Management harmless from any and all liability with respect to harm to or loss of any of Your personal property." - No Liability of Management for Certain Other Losses or Damages. "You acknowledge familiarity with the Apartment, the premises and services of Crest View on 42nd and are therefore willing to, and do, assume all risk associated with occupancy. You further acknowledge that Management is not an insurer of Your safety. Management, its employees, and its agents are not liable to You or to any other person for any	0 970		

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0 970	Continued From page 51 loss or inconvenience of any kind, including personal injuries sustained by You or any other person, for any loss or damage to property, that is not a direct result of intentional or neglect acts in violation of applicable standards of care. For example, Management is not liable to You for any injury, loss, or damage to any property or person, whether caused by fire, explosion, leakage, seepage, bursting, deluge, or overflow of water or sewage or damage occasioned by water, or for any damage arising from acts or negligence of other tenants, or for any loss of any articles by theft, vandalism or any other cause." R4 R4's signed assisted living contract read, -Your Personal Property; No Liability of [licensee]. "We have no responsibility to You or any third party for any personal property placed on the premises by You or the owner of such personal property. We are not responsible to You or any third party for loss of any personal property by theft or any other cause." - No Liability of [licensee] for Losses or Damages. "You acknowledge familiarity with the apartment, the premises and services of Crest View on 42nd and therefore are willing to assume all risks associated with the occupancy. You further acknowledge that We are not an insurer of Your safety. Crest View on 42nd, its employees, and its agents are not liable to You or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by You or any other person, or any loss or damage to property, unless directly caused by Us as a result of intentional or negligent acts. We are not responsible for the actions of, or for any damages, injury or harm caused by, third parties (such as other residents, guests, intruders, or	0 970		

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

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0 970	Continued From page 52 trespassers) who are not under Our control." On June 29, 2023, at 1:06 p.m., licensed assisted living director (LALD)-C acknowledged that R3 and R4's contract contained waivers of liability language and stated, "Anybody that moved in after 144G [regulations] went into effect would have gotten the new contracts and Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), but anyone who moved in prior to that would not have gotten a new one." The licensee's updated contract dated August 2022 did not contain waivers of liability language. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 53 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative 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) 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	01060		

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01060	Continued From page 54 of the residents). The findings include: R1 admitted to licensee on August 2, 2021. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., indicated unlicensed personnel (ULP)-F was alerted R1 was on the ground outside. ULP-F informed kitchen staff person to contact 911. R1 was taken to Unity Hospital to be evaluated. R1's Progress Notes dated November 7, 2022, at 9:36 a.m., written by licensed practical nurse (LPN)-J indicated R1 was extremely intoxicated on Sunday and fell twice in front of the building. LPN-J received a call from a social worker at Unity Hospital informing LPN-J that R1 fractured his hip and Unity Hospital would transport R1 to Mercy Hospital. R1's Progress Note dated December 12, 2022, at 1:11 p.m., written by registered nurse (RN)-M indicated R1 still remained at the hospital and an assessment would be completed upon return. R1's record lacked a written notice with the required statutory content provided to resident or resident representative of emergency relocation. R1's record lacked documentation a notice was sent to the Office of Ombudsman for Long-Term Care (OOLTC) when R1 did not return to the facility within four days. On June 29, 2023, at 1:14 p.m., RN-D stated, "They don't have the emergency relocation form, they don't even know what it is, so I will send it to them, I have it for the other site." RN-D, a	01060		

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01060	Continued From page 55 contracted nurse working for another licensee under the same company, was temporarily filling in for RN-M while on leave of absence. On June 29, 2023, at 3:16 p.m., licensed assisted living director (LALD)-C provided a blank Notice of Emergency Relocation document via email. The licensee's undated Emergency Relocation document indicated the licensee would deliver a written notice to the resident, their legal representative and their designated representative. It also indicated a notice must be delivered to the OOLTC if the resident has not returned within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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.	01290		

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01290	Continued From page 56 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-B). 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: ULP-B ULP-B began employment with the licensee, under the former comprehensive license and started providing assisted living services August 1, 2021. On June 27, 2023, at 7:20 a.m., the surveyor observed ULP-B administer oral medications to R4. ULP-B's employee record contained a background study dated December 29, 2002. ULP-B's record lacked evidence the licensee submitted a background study for ULP-B under the current assisted living with dementia care license and affiliated to the current HFID number. On June 28, 2023, at 12:58 p.m., LALD-C acknowledged ULP-B's background study was in	01290	On June 30, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three widespread violation.	

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01290	Continued From page 57 progress, and LALD-C was unsure how many other staff would need an updated background study and stated, "I would have to check to see who all still needs a background study, I am unsure at this point." On June 28, 2023, at 12:22 p.m., the evaluator observed Minnesota Department of Human Services NETStudy2.0 which indicated ULP-B had a background study that was in process for the HFID associated with the licensee. The licensee's Background Checks policy dated August1, 2021, read, "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. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 58 626.557 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: (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	01470		

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01470	Continued From page 59 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 staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-F, and licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's residents. On June 27, 2023, from 7:20 a.m., through 7:48 a.m., surveyor observed ULP-B provide medication administration and AM cares to R4, while training a newly hired ULP. ULP-B's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for	01470		

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01470	Continued From page 60 the following: -overview of assisted living statutes; -review of provider's policies and procedures -reporting maltreatment of vulnerable adults or minors; -assisted Living bill of rights; -handing of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -initial 8 hours of dementia care training. On June 27, 2023, at 7:58 a.m., ULP-B stated, "I was trained when I was hired but that was over 20 years ago, so I don't recall what all we did." On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. On June 27, 2023, from 11:30 a.m. to 12:12 p.m., surveyor observed ULP-F provide medication administration for four residents and cares to two residents. ULP-F's record lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of the appropriate Assisted Living	01470		

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01470	Continued From page 61 statutes and rules; -handling of emergencies and use of emergency services; - assisted living bill of rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report; - consumer advocacy services; - review of the types of assisted living services the employee will provide and provider's scope of license; - orientation to each specific resident and services provided; and - dementia training required for all direct care staff and supervisors. LPN-A LPN-A was hired May of 2022 per LALD-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LALD-C did not provide the exact date of hire. During the survey from June 26, 2023, through June 29, 2023, surveyor observed LPN-A perform tasks such as medication set-up, medication deliveries, interactions with various residents and performing nursing duties within the nursing office. LPN-A's record lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of the appropriate Assisted Living statutes and rules; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults or	01470		

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01470	Continued From page 62 minors; - assisted living bill of rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report; - consumer advocacy services; - review of the types of assisted living services the employee will provide and provider's scope of license; - orientation to each specific resident and services provided; and - dementia training required for all direct care staff and supervisors. LPN-A's training record transcript dated November 7, 2022, indicated LPN-A completed five point five (5.5) hours out of the required eight hours. On June 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 29, 2023, at 3:10 p.m., the registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control,	01470		

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01470	Continued From page 63 dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated August 1, 2021, indicated the above items would be trained on and the policy read, "All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

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01500	Continued From page 64 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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.	01500		

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01500	Continued From page 65 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-B and ULP-F, licensed practical nurse (LPN)-A). 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: ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's residents. ULP-B's record lacked evidence annual training had been completed as required in the following areas: - reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with resident's challenging behaviors; - review of provider's policies and procedures; and, - principles of person-centered planning/service	01500		

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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
01500	Continued From page 66 delivery. ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. ULP-F's record lacked evidence annual training had been completed as required in the following areas: - Assisted Living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with resident's challenging behaviors; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. LPN-A LPN-A was hired May of 2022 per licensed assisted living director (LALD)-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LPN-A's record lacked evidence annual training had been completed as required in the following areas: - Assisted Living bill of rights; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't	01500		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

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01500	Continued From page 67 have it, if I find it, I will get it to you." On June 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 29, 2023, at 3:10 p.m., the registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not done." The licensee's Assisted Living with Memory Care Annual Training policy dated August 1, 2021, indicated, all assisted living employees would complete annual education on the above-mentioned items, direct-care staff will complete 8 hours of annual training for each 12 months of employment, and annual training would be documented in accordance with the documentation policy. Although requested by the surveyor, the licensee provided no dementia training policies by the	01500		

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01500	Continued From page 68 close of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	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:	01530		

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01530	Continued From page 69 Based on interview and record review the licensee failed to provide evidence of annual dementia care training on required topics for one of one employee (licensed practical nurse (LPN)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective March 1, 2023, through February 29, 2024. LPN-J was hired on June 15, 2015, to provide supervision and oversite to unlicensed personnel and provide direct services residents. LPN-J was a full-time employee and worked Monday through Friday. LPN-J's employee records contained seven reading pages describing myths and facts pertaining to dementia, information on delirium, as well as a ten question quiz on dementia. LPN-J's records lacked any documentation that the annual dementia care training requirements had been completed. On June 29, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "With [LPN-J's] annual training, I was able to find what they [licensee's educator] went over and the	01530		

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01530	Continued From page 70 quizzes but there is nothing I have that shows how much time the dementia training took, just those few sheets of paper on what was covered." On June 29, 2023, at 3:10 p.m., registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." Although requested by the surveyor, the licensee provided no dementia training policies by the close of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another	01540		

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01540	Continued From page 71 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 interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for three of three employees (unlicensed personnel (ULP-B), ULP-F, licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective March 1, 2023, through February 29, 2024. ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's	01540		

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01540	Continued From page 72 residents. ULP-B's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date. ULP-B's General Orientation Checklist For New Employees dated December 2002, included "dementia care training (for direct care staff and supervisors if the agency serves clients with dementia)", but did not specify number of hours. On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. ULP-F's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date. ULP-F's training record dated December 28, 2021, included "elderly-age, diagnoses, dementia specific care," and "additional dementia/ hospice," but did not specify number of hours. ULP-F's Individual Training Record-2021 dated December 28, 2021, indicated ULP-F received general orientation-1.5 hours and skills with a staff person-3 hours. Dementia training was left blank. LPN-A LPN-A was hired May of 2022 per licensed	01540		

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01540	Continued From page 73 assisted living director (LALD)-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LPN-A's training log record dated December 5, 2022, indicated LPN-A completed 5.5 hours of dementia training within 80 working hours of the employment start date. On June 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 29, 2023, at 3:10 p.m., registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." Although requested by the surveyor, the licensee provided no dementia training policies by the close of the survey.	01540		

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01540	Continued From page 74 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments within 14-days following a residents admission date and ongoing	01620		

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01620	Continued From page 75 nursing assessments not to exceed every 90-days thereafter for four of five residents (R1, R5, R3 and R4). In addition, licensee failed to complete a change in condition assessment for one of one resident (R1) after a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CHANGE IN CONDITION R1 was admitted to the licensee and began receiving services on August 2, 2021. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., written by ULP-F indicated R1 was found on the ground outside. R1 was taken to Unity Hospital to be evaluated and later admitted to Mercy Hospital due to a hip fracture. During interview on June 29, 2023, at 10:25 a.m., licensed assisted living director (LALD)-C stated R1 was admitted to the transitional care unit (TCU) on November 11, 2022, and returned to licensee on January 12, 2023. R1's record lacked a change in condition assessment upon R1's return on January 12, 2023. R1's most recent RN comprehensive assessment completed was on June 2, 2022. RN ASSESSMENT	01620		

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01620	Continued From page 76 R3 R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's record lacked timely 90-day nursing assessments. R3 had AL Assessments dated October 17, 2022, January 30, 2023, and the most recent assessment was March 16, 2023. R4 R4 was admitted to the licensee and began receiving services on March 10, 2012. R4's record lacked timely 90-day nursing assessments. R4 had AL Assessments dated August 3, 2022, December 14, 2022, and the most recent assessment was March 16, 2023. R5 R5 was admitted to the licensee and began receiving services on November 30, 2022. R5's record lacked timely 90-day nursing assessments. R5's most recent RN comprehensive assessment was dated March 13, 2023. On June 26, 2023, at 10:43 a.m., during the entrance conference, licensed assisted living director (LALD)-C identified the RN is responsible for completion of documentation and assessments of residents residing in the facility. Licensed practical nurse (LPN)-J indicated licensee's expectation were: -an initial assessment upon admission, another within 14 days of the initial assessment, every 90 days, or with any change of condition. On June 29, 3:03 p.m., RN-D stated for a hospital return, she would expect in the resident's chart, a	01620		

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01620	Continued From page 77 full nursing assessment completed, any changes to the service plan with approval by resident, and documentation in progress notes. On June 29, 2023, at 3:18 p.m., RN-D stated, "Ideally you do them [90-day assessments] on the 87th day because at 91 days they are late. I think that's a fair statement when I say that they [licensee's nurses] need to print a roster and start to do assessments. They all need to be done so they are up to date." The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy, dated August 1, 2021, read "A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640		

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01640	Continued From page 78 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a service plan in place documenting agreement on the services to be provided for one of five residents (R5). The licensee also failed to ensure service plans included signatures or other authentication by the residents and the licensee to document agreement on the change of services to be provided 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) 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).	01640		

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01640	Continued From page 79 The findings Include: R5 R5 began receiving assisted living services on November 30, 2022. R5's record lacked a signed service plan. On June 29, 2023, at 12:56 p.m., surveyor requested R5's signed service plan from admission and licensed assisted living director (LALD)-C stated she did not have one to provide. R5's Task List Report printed June 30, 2023, indicated R5 received weekly medication set up, daily homemaking, daily linen, and the following are on an as needed basis: pull cord, shower assistance, escorts, laboratory coordination, and additional services by ULP. R1 R1 was admitted to the licensee on August 2, 2021. R1's signed service plan dated August 2, 2021, indicated R1 would receive monthly vital signs checks (blood pressure, heartrate, respiration, oxygen level and temperature) and weight check, care coordination (help with appointment set up and transportation) as needed, telehealth visits as needed, pull cord response as needed and Coronavirus vital sign checks twice a day. R1's RN Comprehensive Assessments dated November 26, 2021, March 2, 2022, June 2, 2022, and August 8, 2022, indicated R1 was assessed to receive medication management, and weekly housekeeping services. R1's record included a service plan which was not	01640		

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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
01640	Continued From page 80 dated nor signed by resident or the licensee agreeing to add medication administration by unlicensed personnel and weekly medication setup by a licensed nurse. R1's task record dated June 1, 2023, through June 30, 2023, indicated staff were documenting medication administration. On June 29, 2023, RN-D stated if a change was made to the service plan, it should be printed, signed by resident or family, and included in the resident's chart. The licensee's Residency Agreement Attachment D-Service Plan dated August 2022, indicated a written service plan must include: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences. The document also indicated the initial service plan, and each revision must be signed by both the resident and an authorized representative of the provider. TIME PERIOD TO CORRECT: Seven (7) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided.	01700		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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01700	Continued From page 81 This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that based on the assessment, the registered nurse (RN) determined what medication management services would be provided, and how the services would be provided for one of four residents (R5). 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:	01700		

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01700	Continued From page 82 R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. R5's service agreement was requested, but not received. R5's prescriber orders, signed November 25, 2022, included one anxiety medication, two inhalers, two nebulizer medications, one nasal spray, one cholesterol medication, two diabetic medications, one sleep aid, one pain medication, and one blood pressure medication. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's [Licensee] Home Care Medication Assessment dated November 30, 2022, assessed R5 could self-administer her medications and medications would be stored within R5's apartment and managed by R5. R5's assessment indicated R5 would need medication reminders, and indicated, "resident wishes to control her own medications." Under additional comments, RN indicated staff to monitor and ensure safety. R5's assessment lacked evidence the RN had determined what medication management services would be provided, and how the services would be provided for R5. R5's assessment also lacked evidence of assessment on administering subcutaneous injections. R5's Task List Report printed June 30, 2023, indicated R5 received weekly scheduled	01700		

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01700	Continued From page 83 medication set up by placing medications into specific containers and delivered to the room. RN to assess medication compliance, observation of drug interactions and responses to medications. R5's Medication Administration Record (MAR) dated June 1, 2023, through June 30, 2023, listed the medications R5 was ordered to take scheduled at various times at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m., and as needed (PRN). The following medications on the MAR indicated "U-SA" (unsupervised self-administration): -trazodone 50 milligram (mg) ½ tablet daily for sleep; -hydrochlorothiazide 12.5 mg-1 tablet daily for high blood pressure; -fluticasone Furoate 50 microgram (mcg)-inhale 1 orally daily for COPD; -aspirin 81 mg-1 tablet daily to thin blood; -atorvastatin calcium 40 mg-1 tablet daily for high cholesterol; -celecoxib 200 mg-1 capsule daily for swelling; -clotrimazole cream 1%-apply to affected area topically twice a day for rash; -eye vitamins-2 capsules daily to supplement; -humulin 70/30 suspension 100 unit/milliliters (ml)-inject 20 units subcutaneously twice a day for diabetes; -hydrocortisone ointment 1%-apply to affected areas topically two times a day for dermatitis; -lisinopril 40 mg-1 tablet daily for high blood pressure; -omeprazole 20 mg-1 capsule daily for stomach; -albuterol sulfate 108 mcg- inhale two puffs four time a day for shortness of breath; -albuterol sulfate 108 mcg-inhale two puffs every 6 hours for shortness of breath; and -triamcinolone acetonide external cream 0.1%-apply to skin topically two times a day for rash	01700		

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01700	Continued From page 84 The following medications on the MAR were documented by staff on various shifts and various days of the month: -buspirone 5 mg-1 tablet twice a day for anxiety on 23 scheduled times between June1 through June 27, 2023-6 of those documented "drug refused," and 5 of those documented, "other/ see nurse notes." Twenty-nine scheduled times were left blank; -buspirone 10 mg- tablet twice a day for anxiety on two scheduled times between June 27 through June 30, 2023-one documented, "other/ see nurse notes." Four scheduled times were left blank; -metformin 500 mg-two tablets twice a day for diabetes on 23 scheduled times for June 1 through June 30, 2023-6 of those documented, "drug refused." Four of those documented, "other/ see nurse notes." Thirty-seven scheduled times were left blank. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. R5 stated she received assistance with housekeeping. When surveyor asked if she was assessed by an RN after admission, she stated, "not that I remember." R5 stated a nurse from a homecare agency assisted her on a routine basis. Surveyor observed on top of the refrigerator two boxes containing daily medications in plastic pouches labeled date and time and contents of the medications. Behind those boxes were bubble cards of medications stacked behind the boxes of medications. During interview on June 29, 2023, at 2:54 p.m., unlicensed personnel (ULP)-N stated R5 provided	01700		

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01700	Continued From page 85 her with blood glucose results, but she didn't know why she charted that she administered R5's medications. During interview on June 29, 2023, at 3:03 p.m., RN-D stated if there were blank spots on the MAR, it meant the medication was not given or was not documented. RN-D stated when an ULP logs out of the electronic health record, it would prompt the ULP to complete charting. RN-D stated blanks on the MAR would be considered a medication error. If a medication error occurred, RN would re-educate ULP and go over the medication error policy with ULP. The licensee's Medication Management Services policy dated April 24, 2023, indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and would develop specific procedures that staff would provide. The director of nursing would assure that unlicensed personnel are trained, competent and oriented to the resident whenever unlicensed personnel are to perform medication management services for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management	01710		

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01710	Continued From page 86 services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment on the resident's medication management services after a change in condition for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on August 2, 2021, with diagnoses that included alcohol abuse, protein-calorie malnutrition, and atrial fibrillation (irregular heartrate). R1's Service Plan signed August 2, 2021, indicated R1 received monthly vital sign checks (blood pressure, temperature, weight, oxygen level, respiration count and heart rate), as needed (PRN) care coordination including appointment arrangement and transportation, PRN telehealth visits, PRN call button response, and scheduled vital sign checks twice a day related to Coronavirus.	01710		

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01710	Continued From page 87 R1's RN Comprehensive Assessment dated November 26, 2021, assessed R1 to receive medication management services to include medication administration by staff, and RN to monitor weekly for accuracy, availability, and compliance. R1's RN Comprehensive Assessment dated August 8, 2022, did not include all contents of the uniform assessment tool requirements of Minnesota Rule 4659.0150. The assessment did not indicate whether there was a change to R1's medications but it did indicate R1 was taking two vitamins. R1's physician orders dated July 23, 2021, ordered R1 to take Thamine 100 milligram (mg) daily for malnutrition/alcohol abuse and folic acid 1 mg tablet-1 tablet daily for malnutrition, alcohol abuse. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., ULP-F indicated R1 was found on the ground outside. ULP-F and a kitchen staff person went to assist R1 off the ground. R1 refused to come inside the building so staff went back inside. Fifteen minutes later R1 fell again outside. Witnesses saw R1 throw away an empty liter bottle of whiskey. R1 was taken to Unity Hospital to be evaluated. R1's Progress Notes dated November 7, 2023, at 9:36 a.m., indicated LPN-J was informed by a social worker at Unity Hospital that R1 fractured his hip and was being relocated to Mercy Hospital. R1's Progress Notes dated December 12, 2022, RN-M indicated R1 remained hospitalized, and an	01710		

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01710	Continued From page 88 assessment would be completed upon return. R1's record lacked evidence of his return from the hospital. During interview on June 29, 2023, at 10:25 a.m., licensed assisted living director (LALD)-C indicated R1 was admitted to the transitional care unit (TCU) on November 11, 2022, and returned to licensee on January 12, 2023. R1's Medication Administration Record (MAR) dated December 1, 2023, through December 31, 2023, indicated the following: -folic acid 1 mg tablet-1 tablet by mouth once daily at 8:00 a.m. From December 1, through December 31, there was no documentation folic acid was given; and -thiamine 100 mg tablet-1 tablet by mouth once daily at 8:00 a.m. Areas for staff to document administration were documented with "H." According to the MAR chart code, "H" meant "on hold by physician." R1's MAR dated January 1, 2023, through January 31, 2023, indicated the following: -folic acid (same as above), indicated it was given by staff on January 19, 24, 25, 27, and 30; -thiamine (same as above), was documented with an "H." R1's MAR dated June 1, 2023, through June 30, 2023, did not indicate any medications were scheduled. R1's service documentation record June 1, 2023, through June 30, 2023, indicated R1 received medication administration on June 3, 11, 14, and 26, 2023, at 8:00 a.m., while the rest of the days were left blank.	01710		

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01710	Continued From page 89 R1's care plan printed on June 28, 2023, indicated R1 received the following services: medication administration by ULP, safety checks, behavioral interventions, and monthly vital sign check. R1's record lacked evidence the RN conducted an assessment for either change in condition or quarterly assessment since August 8, 2022. R1's record lacked documentation of when licensee stopped providing medication administration to R1. R1's record also lacked an RN re-assessment to determine if R1 could self-administer his medications. On June 28, 2023, at 9:37 a.m., LPN-J stated around March of 2023, medication management services for R1 stopped. LPN-A could not explain why ULP's were documenting medication administration on R1's June 2023, MAR. On June 29, 2023, at 3:03 p.m., RN-D stated following a change in condition, the RN should have conducted a comprehensive reassessment and updated the service plan if applicable and those should be in R1's record. On June 30, 2023, at 8:10 a.m., ULP-G stated she did not administer medications for R1, it wasn't on her task list. She stated, "I don't do much for him." The licensee's Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency policy dated July 29, 2021, effective August 1, 2021, indicated the RN would reassess the resident if the resident has a change in condition. At these	01710		

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01710	Continued From page 90 reassessments, the RN will: -review the resident's service plan; -evaluate the resident's medication management services and the resident's medications; -evaluate the resident's treatments, if any; -communicate any new problems or concerns to the resident's physician or health care providers, and; -update the service plan as necessary based on the resident's needs. The result of the resident monitoring visits and reassessments would be documented by the licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	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;	01730		

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01730	Continued From page 91 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for one of four residents (R5). 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	01730		

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01730	Continued From page 92 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. R5's service agreement was requested, but not received. R5's prescriber orders signed November 25, 2022, included one anxiety medication, two inhalers, two nebulizer medications, one nasal spray, one cholesterol medication, two diabetic medications, one sleep aid, one pain medication and one blood pressure medication. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's [Licensee] Home Care Medication Assessment dated November 30, 2022, assessed R5 could self-administer her medications and medications would be stored within R5's apartment and managed by R5. R5's assessment indicated R5 would need medication reminders, and indicated, "resident wishes to control her own medications." Under additional comments, RN indicated staff to monitor and ensure safety. R5's assessment lacked evidence the RN had determined what medication management services would be provided, and how the services would be provided for R5. R5's assessment also lacked evidence of assessment	01730		

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01730	Continued From page 93 on administering subcutaneous injections. R5's Task List Report printed June 30, 2023, indicated R5 received weekly scheduled medication set up by placing medications into specific containers and delivered to the room. RN to assess medication compliance, observation of drug interactions and responses to medications. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. R5 stated she received assistance with housekeeping. When surveyor asked if she was assessed by an RN after admission, she stated, "not that I remember." R5 indicated a nurse from a homecare agency assisted her on a routine basis. Surveyor observed on top of the refrigerator two boxes containing daily medications in plastic pouches labeled date and time and contents of the medications. Behind those boxes were bubble cards of medications stacked behind the boxes of medications. On June 30, 2023, at 8:10 a.m., unlicensed personnel (ULP)-G stated R5's medications show up on the electronic medication administration record (EMAR), but nurses told her R5 does her own medications. On June 27, 2023, at 1:21 p.m., RN-D stated nursing staff would use the weekly set up service because the service included ordering of meds and monitoring of medications by nursing staff. R5's record lacked a clear and concise medication management plan to include the following required content: -a statement describing the medication	01730		

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01730	Continued From page 94 management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. The licensee's Medication Management Services policy dated April 24, 2023, indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and would develop specific procedures that staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750		

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01750	Continued From page 95 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for 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 prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure for two of two employees (ULP-B, ULP-F). 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: ULP-B ULP-B began employment with the licensee, under the former comprehensive license and started providing assisted living services on	01750	On June 30, 2023, the immediacy of correction order 1750 was removed, however non-compliance remained at a level three widespread violation.	

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01750	Continued From page 96 August 1, 2021. ULP-B's employee record lacked a competency evaluation completed by a RN for medication administration. On June 27, 2023, from 6:52 a.m., until 8:40 a.m., surveyor observed ULP-B training a new hire ULP on tasks, medication administration, and services in the secured memory care. On June 27, 2023, at 7:20 a.m., the surveyor observed ULP-B administer oral medications to R4. ULP-F ULP-F began employment with the licensee and started providing assisted living services on December 17, 2021. ULP-F's employee record lacked a competency evaluation completed by a RN for oral medication administration. During observation and interview on June 27, 2023, at 12:12 p.m., ULP-F set up R15's scheduled noon medication and brought the medication into R15's room where she was laying on her bed. ULP-F instructed R15 to administer the medication and R15 stated "do I have to take it right now?" ULP-F stated yes, and R15 then asked ULP-F, "will this be everyday now?" After the medication administration, ULP-F admitted to surveyor that "I always set up the medication and R15 will hold it until her nap." Surveyor asked what time R15 usually took a nap and ULP-F stated 1:30 p.m. On June 27, 2023, at 8:10 a.m., ULP-B stated, "We [the ULPs] train the new people how to do	01750		

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01750	Continued From page 97 the meds, that is our job, we just train each other." On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration dated August 1, 2021, indicated the registered nurse (RN) would instruct and competency test the ULP's in medication administration, treatment and therapy and determine the ULP to be competent to perform tasks, and the RN would document the training and competencies in the ULP's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 98 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 medication was administered as prescribed for two of four residents (R3, R4), and failed to ensure that medications were administered per protocol for two of four residents (R3, R4). The licensee also failed to transcribe provider orders correctly for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: OMISSION R3 R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's medication administration record (MAR)	01760		

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01760	Continued From page 99 dated June 1, 2023, through June 30, 2023, indicated staff did not administer the following with no reason documented: - 5:45 a.m. medications which included paroxetine hydrochloride 50 milligrams (mg), acetaminophen 1000 mg, calcium carbonate 500 mg, cetirizine hydrochloride 10 mg, cholecalciferol 125 micrograms (mcg), clonazepam 0.5 mg, Depakote sprinkles 125 mg, fiber-lax 625 mg, fluticasone propionate suspension 50 mcg, gabapentin 100 mg, lactulose 10 gram (g)/ 15 milliliter (ml), and levothyroxine sodium tablet 75 mcg on June 2, 10, 11, 16, 24, 25 and 30; - 5:45 a.m. medications which included Aspercreme Lidocaine external cream 4 percent (%), and Baclofen oral tablet 5 mg on June 10, 11, 16, 24, 25 and 30; - 12:00 p.m. medications which included acetaminophen 1000 mg and gabapentin 100 mg on June 1,6, 8, 13, 20, 22, 27 and 29; - 12:00 p.m. medications which included Baclofen oral tablet 5 mg on June 8, 13, 20, 22, 27 and 29; and - 8:00 p.m. medications which included acetaminophen 1000 mg, Aspercreme Lidocaine external cream 4%, Baclofen oral tablet 5 mg, calcium carbonate 500 mg, clonazepam 0.5 mg, Depakote sprinkles 125 mg, and gabapentin 100 mg on June 18, 19 and 21. R4 R4 was admitted to the licensee and began receiving services on March 10, 2012. R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R4's signed service plan dated October 16, 2020,	01760		

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01760	Continued From page 100 indicated R4 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and behavior monitoring/redirection. R4's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated staff did not administer the following with no reason documented: - 4:00 p.m. medications which included acetaminophen 650 mg on June 1 on June 18, 19 and 21; - 8:00 p.m. medications which included metronidazole cream 0.75%, mirtazapine 7.5 mg, Depakote ER 250 mg, memantine hydrochloride 5mg, metoprolol tartrate 25mg, olanzapine 5mg, ProAir inhalation aerosol solution 108 mcg, Systane balance solution 1 drop, acetaminophen 650 mg, on June 18, 19 and 21; and - 8:00 p.m. medications which included Aquaphor ointment, Budesonide suspension 1mg/2ml, petroleum jelly gel, on June 2, 18, 19 and 21. ADMINISTRATION PROTOCOL ERROR R3 During observation on June 28, 2023, at 12:42 p.m., surveyors observed R3 sitting at the dining room table in the locked memory care unit eating her meal with a plastic clear medication cup with medications in it next to R3 on the table. Surveyor observed unlicensed personnel (ULP)-N sitting in a chair on the other side of the dining room. During interview on June 28, 2023, at 12:43 p.m., surveyor asked ULP-N if she had set up R3 medications and she stated no, she did not. ULP-N stated she was observing the memory care unit because ULP-F went on break five minutes prior to surveyors' arrival.	01760		

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01760	Continued From page 101 During interview on June 28, 2023, at 12:47 p.m., licensed practical nurse (LPN)-J stated staff were expected to set up and administer medications off the electronic medication record and practice the "6 rights of medication administration." LPN-J also indicated staff are to stay with the resident until medications are swallowed. LPN-J stated, "That's not good," when she was made aware of the situation. During interview on June 28, 2023, at 2:30 p.m., ULP-F stated ULP-N was sitting in memory care watching R3. ULP-F indicated R3 wanted to eat first then take her medications. ULP-F said she notified ULP-N to watch R3 take them. ULP-F then stated, "it looked like R3 was going to take them, put it to her mouth like it was water, then put the medication cup back down." "Usually when medications are given, I watch residents take them." R4 R4's Medication Assessment dated May 31, 2023, indicated staff would manage and administer all of R4's medications including inhalant medications. On June 27, 2023, at 8:05 a.m., surveyor observed ULP-B set up R4's nebulizer medication and hand it to R4. ULP-B then left the room and stated to a trainee, "we have to leave her, or she freaks out and she won't take the nebulizer, but if you leave her to do it alone, she does a good job of taking it. She tells us when there is an issue like earlier when she was telling me that it was leaking so I looked and there was a crack in the plastic, so she is very reliable and will take the nebulizer by herself."	01760		

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01760	Continued From page 102 On June 27, 2023, at 12:58 p.m., registered nurse (RN)-D stated, "she is not approved to administer her own nebs. Her assessment is marked that the ULP should be doing it and there is nothing in the orders that says she is ok to self-administer." TRANSCRIPTION ERROR R5 R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's physician orders dated April 20, 2023, ordered metformin 500 mg tablet extended release-2 tablets by mouth two times a day with meals for diabetes. R5's physician orders dated April 25, 2023, ordered metformin 850 mg tablet-1 tablet by mouth two times a day with meals for diabetes. The following medication on the MAR was documented by staff on various shifts and various days of the month: -metformin 500 mg-two tablets twice a day for diabetes on 23 scheduled times for June 1 through June 30, 2023-(6) of those documented, "drug refused." Four of those documented, "other/ see nurse notes." Thirty-seven scheduled times were left blank. During interview on June 30, 2023, at 12:29 p.m.,	01760		

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01760	Continued From page 103 RN-D stated they tried to figure out the metformin order and RN-D was told by R5 that 1000 mg upset her stomach, so the physician decreased the dose to 850 mg. RN-D stated the LPN manually entered in the order on the MAR. RN-D stated they asked LPN-J about the order and LPN-J could not explain why the 1000 mg was still on the MAR and not the 850 mg dose. RN-D also stated there was no progress note to explain the discrepancy. On June 27, 2023, at 1:00 p.m., RN-D stated, "Medications should be documented after administration, if it is not documented it didn't happen and that should have been reported to the nurses to investigate. So, I will look into why there is no documentation." The licensee's Medication Management Services policy dated April 24, 2023, indicated a nurse would review the resident's medication record during medication setups, monitoring visits, and other appropriate times to verify staff are administering the medications as prescribed and are documenting the admission appropriately with authentication be each staff person by discipline or title. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820		

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01820	Continued From page 104 managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R3). 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: R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's Medication Administration Record (MAR), dated June 1, 2023, through June 30, 2023, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that Levothyroxine 75 micrograms (mcg) was administered once daily on June 1, 3-9, 12, 13,	01820		

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01820	Continued From page 105 15, 17-23, and 26-29. ClonazePam 0.5 milligram (mg) was administered once in the mornings on June 1, 3-9, 12-15, 17-23, and 26-29, and once in the evenings on June 1-17, 20, and 22-29. Cholecalciferol 125 mcg was administered once daily on June 1, 3-9, 12, 13, 15, 17-23, and 26-29. Cetirizine hydrochloride10 mg was administered once daily on June 1, 3-7, 9, 12, 13, 15, 17-23 26, and 27. Baclofen oral tablet 5 mg was administered once daily on June 7, twice daily on June 8, 10, 11, 13, 14, 16,18-22, 24, 25, 27 and 29, and three times daily on June 9, 12, 15, 17, 23, 26, and 28. Aspercreme Lidocaine external cream 4 percent (%) was administered in the mornings on June 3-9, 12-15, 17-23, and 26-29, and once in the evenings on June 4-17, 20, and 22-29. R3's most recent provider orders for the following 12 medications were signed on February 8, 2022. -Levothyroxine 88 micrograms (mcg) by mouth one time daily; -Depakote sprinkles 125 milligrams (mg) by mouth two times daily; -Fiber-Lax 625 mg by mouth one time daily; -fluticasone propionate suspension 50 mcg -ibuprofen 600 mg every six hours as needed; -lactulose solution 10 grams (gm) per milliliter (ml) by mouth one time daily; -meclizine hydrochloride 25 mg by mouth every eight hours as needed; -calcium carbonate-vitamin D by mouth two times daily; -Paroxetine hydrochloride 50 mg by mouth one time daily; -multivitamin by mouth one time daily; and -vitamin D3 25 mcg by mouth one time daily. The surveyor did not receive signed orders for the following medications prior to survey completion:	01820		

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01820	Continued From page 106 -Levothyroxine 75 mcg orally one time a day, -ClonazePam 0.5 mg orally two times a day, -Cholecalciferol 125 mcg orally one time a day, -Cetirizine hydrochloride10 mg orally one time a day, -Baclofen oral tablet 5 mg orally three times a day, and -Aspercreme Lidocaine external cream 4% apply to feet topically two times a day. On June 29, 2023, at 10:15 a.m., licensed assisted living director (LALD)-C acknowledged the most recent signed annual orders that were dated February 8, 2022, were the orders the licensee had on file. LALD-C stated, "those are the only orders we have for [R3] in her files." On June 29, 2023, at 3:23 p.m., registered nurse (RN)-D who was a contract nurse filling in while the clinical nurse supervisor was on leave, stated, "We have to have a prescription order no matter what the medication is if we are giving it. You can't give a med without an order. I have no idea why there is no orders for those medications." The licensee's Medication Prescriptions, Refills, Supplies-Requests & Delivery policy dated April 24, 2023, indicated the RN would be responsible to obtain signed orders for all medications that would be managed by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12	01830		

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01830	Continued From page 107 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R3). 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: R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's most recent provider orders for the following 12 medications were signed on February 8, 2022. -Levothyroxine 88 micrograms (mcg) by mouth one time daily;	01830		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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01830	Continued From page 108 -Depakote sprinkles 125 milligrams (mg) by mouth two times daily; -Fiber-Lax 625 mg by mouth one time daily; -fluticasone propionate suspension 50 mcg -ibuprofen 600 mg every six hours as needed; -lactulose solution 10 grams (gm) per milliliter (ml) by mouth one time daily; -meclizine hydrochloride 25 mg by mouth every eight hours as needed; -calcium carbonate-vitamin D by mouth two times daily; -Paroxetine hydrochloride 50 mg by mouth one time daily; -multivitamin by mouth one time daily; and -vitamin D3 25 mcg by mouth one time daily. On June 29, 2023, at 1:16 p.m., registered nurse (RN)-D stated, "Prescription orders need to be renewed every 12 months or sooner. There is no reason these shouldn't have been renewed, the providers round here in the building." The licensee's Medication Prescriptions, Refills, Supplies-Request & Delivery policy dated April 24, 2023, indicated the nurse would assure that the prescriber renews a medication prescription every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 109 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 discard expired medication for nine of 11 residents (R10, R11, R12, R13, R14, R15, R16, R17, and R20). 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: On June 27, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the medication cart within the nursing office was used for overstock (extra) medications, and medication set ups. LPN-A stated they did not have a process for checking for expired medications. EXPIRED MEDICATIONS -R10-eight (8) expired medications ranging from October 31, 2018, through June 1, 2023; -R11-five (5) expired medications ranging from September 30, 2022, through June 1, 2023; -R12-two (2) expired medications on May 1, 2023, and June 1, 2023; -R13-five (5) expired medications ranging from	01890		

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01890	Continued From page 110 January 31, 2023, through June 1, 2023; -R14-two (2) expired medications on October 18, 2022, and February 24, 2023; -R15-two (2) expired medications on March 31, 2023, and May 31, 2023; -R16-one (1) expired medication on April 1, 2023; -R17-one (1) expired medication on February 28, 2023; and -R20-one (1) expired medication on March 31, 2023. During interview on June 29, 2023, at 3:03 p.m., registered nurse (RN)-D stated licensee should have been doing medication cart audits every two weeks to check for expired medications. RN-D stated it was not okay to hold onto any expired residents' medication and should be destroyed. RN-D also stated all medications should bear original label and if it is over the counter medication, it should have first initial and full last name of a resident. The licensee's Storage of Medications policy dated July 29, 2021, effective August 1, 2021, indicated 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 quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The licensee's Disposition or Disposal of Medication policy dated July 29, 2021, effective August 1, 2021, indicated the licensee would destroy unused or discontinued medications and document the date it was destroyed, quantity, name of drug, prescription number, signature of	01890		

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01890	Continued From page 111 person destroying the medications, and signature of witness to the destruction. The destruction record must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications were destroyed when medications were no longer	01910		

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01910	Continued From page 112 in use. This had the potentional to affect all residents receiving medication management. 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: On June 27, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the medication cart within the nursing office was used for overstock (extra) medications, and medication set ups. LPN-A stated they did not have a process for checking for expired medications. Surveyor asked if licensee had central house stock medications, which any resident with a provider order can use over-the-counter medications. LPN-A stated licensee did not use central house stock medications. Every resident had their own medications. On June 27, 2023, at 9:25 a.m., surveyor observed bottles of Miralax (used for constipation) where the residents names were blocked out by a black sharpie pen. LPN-A stated, "they were probably used for other residents if someone ran out", and "I hate to toss them." LPN-N showed surveyor where staff document medication destruction when medications either expire or when resident discharges. In addition, the following medications were	01910		

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01910	Continued From page 113 observed to have the top part of the bubble pack ripped off or pharmacy label missing from the bottle which contained the name of resident, name of medication, dose, and instructions how to take them: -vitamin B12 500 micrograms (mcg)-1/3 of bottle, expires on October, 2025; -pain relief 325 milligrams (mg), 1/4 of bottle, expires May, 2025; -senna 8.6 mg, new sealed bottle, expires November 2025; -vitamin D3 2000 units (u), 25 pills expired on March 1, 2023; -furosemide (diuretic) 40 mg, 7 pills, expires on July 1, 2023; -Narcan spray (for overdose) 4 mg nasal spray, 2 sprays, expired September, 2021; -atorvastatin (high cholesterol) 40 mg, 25 pills, expired on June 30, 2022; and -polyethylene glycol 3350, 14 packets, expires December, 2024. During interview on June 29, 2023, at 3:03 p.m., registered nurse (RN)-D who was a contract nurse filling in while the clinical nurse supervisor was on leave, stated licensee should have been doing medication cart audits every two weeks to check for expired medications. RN-D stated it was not okay to hold onto any expired residents' medication and the medications should be destroyed. RN-D also stated all medications should bear original label and if it is over-the-counter medication, it should have first initial and full last name of a resident. The licensee's Storage of Medications policy dated July 29, 2021, effective August 1, 2021, indicated a legend drug must be kept in its original container bearing the original prescription label with legible information stating the	01910		

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01910	Continued From page 114 prescription number, name of drug, strength, and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The licensee's Disposition or Disposal of Medication policy dated July 29, 2021, effective August 1, 2021, indicated the licensee would destroy unused or discontinued medications and document the date it was destroyed, quantity, name of drug, prescription number, signature of person destroying the medications, and signature of witness to the destruction. The destruction record must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	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	01940		

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01940	Continued From page 115 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 a treatment management plan to include all required content for one of one resident (R5) with blood glucose monitoring and continuous positive airway pressure (CPAP) machine. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on	01940		

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01940	Continued From page 116 November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. Surveyor observed a CPAP machine on the floor next to R5's bed. R5 stated the licensee was charging her $16 dollars per day to record her blood glucose checks she performs three times a day. R5 also stated, "a lot of times, they don't ask me the results." R5's admission orders signed November 25, 2022, ordered to check blood glucose three times a day. On the same order, it indicated CPAP equipment was being ordered. R5's most recent Registered Nurse (RN) Comprehensive Assessment dated March 13, 2023, did not assess whether R5 needed assistance with blood glucose checks or CPAP machine. Under "Review," it indicated the RN reviewed the individual treatment/therapy plan. R5's record lacked a service plan. R5's Task List Report printed June 30, 2023, indicated R5 received weekly medication set up, daily homemaking, daily linen, and the following on an as needed basis: pull cord, shower assistance, escorts, laboratory coordination, and additional services by ULP. R5's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated to check blood glucose three times a day for monitoring at 8:00 a.m., 11:00 p.m., and	01940		

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01940	Continued From page 117 4:00 p.m. which was initiated November 30, 2022. The MAR also had a duplicate to check blood glucose three times a day instructing staff to ask R5 what her blood glucose result was and to record at the same times. The duplicate was initiated on December 1, 2022. For the month of June 2023, out of 90 records, 49 were documented. R5's record lacked a Medication Treatment therapy Management Plan to include the following content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -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. On June 29, 2023, at 2:15 p.m., ULP-N stated she initially observed R5 check her own blood glucose, but had not observed it for a while. R5 will just tell her what the result was. On June 30, 2023, at 12:29 p.m., RN-D confirmed there were no instructions on when to notify the nurse if a blood glucose was low or high. RN-D stated the treatment should have been included in the RN assessment.	01940		

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01940	Continued From page 118 The licensee's Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency policy dated July 29, 2021, effective August 1, 2021, indicated the RN comprehensive assessment would include a list of treatments including the type, frequency and level of assistance needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by:	01950		

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01950	Continued From page 119 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident receiving blood glucose monitoring (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. R5 stated the licensee was charging her $16 dollars per day to record her blood glucose checks she performs three times a day. R5 also stated, "a lot of times, they don't ask me the results." R5's admission orders signed November 25, 2022, ordered to check blood glucose three times a day. R5's record lacked a service plan.	01950		

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01950	Continued From page 120 R5's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated to check blood glucose three times a day for monitoring at 8:00 a.m., 11:00 p.m., and 4:00 p.m. which was initiated November 30, 2022. The MAR had a duplicate to check blood glucose three times a day instructing staff to ask R5 what her blood glucose result was and to record at the same times. The duplicate was initiated on December 1, 2022. For the month of June 2023, out of 90 records, 49 were documented. During this time frame blood glucose results ranged from 128 to 281 milligrams (mg)/deciliter (dL). R1's record lacked specific written instructions for blood glucose monitoring to include parameters for evaluation of results. During interview on June 30, 2023, at 8:10 a.m., ULP-G was working on the unit R5 lived in. ULP-G stated she asks R5 for the blood glucose results, but has never seen R5 check her blood glucose nor the book she keeps track of her results in. Surveyor asked ULP-G if there were instruction on when to notify the nurse and ULP-G stated, "I don't think so, but I have been trained on it a long time ago for another resident." On June 30, 2023, at 12:29 p.m., RN-D confirmed there were no instructions on when to notify the nurse if a blood glucose was low or high. The licensee's Treatment and Therapy Management policy dated April 24, 2023, indicated the licensee would provide written instructions of when to notify a licensed nurse when problems arose with treatments or therapies.	01950		

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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
01950	Continued From page 121 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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02040	Continued From page 122 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45 a.m. On June 29, 2023, at approximately 2:00 p.m., a document review and interview with the LALD-C, the DOM-I, and the M-K relating to the memory care site-specific safety risk/vulnerability assessment and mitigation plan indicated the licensee lack the required plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. Survey staff requested documentation for the review, but one was not provided or available for review, and the finding was confirmed during the interview with the LALD-C and DOM-I that the licensee lacked the required plan. Survey staff discussed the finding and explained that all potential safety risks and/or vulnerabilities specific to memory care residents on and around the property must be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. On June 29, 2023, at approximately 2:30 p.m., during the exit interview, the M-K, the LALD-C, and DOM-I acknowledged the above findings. No further information was provided.	02040		

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02040	Continued From page 123 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an awake person was physically present in a secured care unit, 24 hours a day, seven days a week who was responsible for responding to requests of residents for assistance in a secured area. This had the potential to affect all residents in the secured dementia care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7 was admitted on January 31, 2022, and	02070		

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02070	Continued From page 124 resided in the unsecured area of the facility. R7's Resident Incident Report dated June 26, 2023, at 2:50 a.m., read, "resident observed on floor sitting by her chair. She stated she slid down from her recliner." The licensee's daily schedule provided by LALD-C dated June 22 - July 5, 2023, indicated two (2) staff members were working on the NOC (commonly used term for the overnight) shift. One staff was assigned to the secured unit, and one assigned to the unsecured unit. On June 27, 2023, at 6:10 a.m., unlicensed personnel (ULP)-H stated they sometimes leave the secured memory care unit on the overnights to assist with a fall in the unsecured unit. ULP-H stated, "We [staff] call each other on the walkies and if she [other staff] needs my help I will leave here [secured memory care unit] and go help her, I am always going up to [R7's] to help get her up off the floor. I don't go right away; I go and check my residents that are fall risks and then once I ensure they are safe then I go. Sometimes I can't go right away because sometimes I need to toilet someone or get them settled down before they are safe to leave. This happened just night before last [June 26, 2023], I remember because my shoulder still hurts from it." On June 27, 2023, at 8:42 a.m., LALD-C stated, "what we do for staffing is one person and the float who is the person assigned to the third group [on the morning and afternoon shift] is the back up for memory care. Right now, with there being just a few people [residents] the needs are not that high, but someone is always supposed to be in there [the secured unit]. For over nights memory care staff can't leave memory care. But I	02070		

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02070	Continued From page 125 did look at our policy and our staffing plan and they don't actually say that the memory care staff can't leave the unit, so I will need to do some re-education with them." The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated, August 1, 2021, read, "A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		
02110 SS=C	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: (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	02110		

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02110	Continued From page 126 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 ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for four of four residents (R1, R3, R4, and R5). 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 the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee on August 2, 2021.	02110		

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02110	Continued From page 127 R3 was admitted to the licensee on September 6, 2019. R4 was admitted to the licensee on March 10, 2012. R5 was admitted to the licensee on November 30, 2022. R1, R3, R4 and R5's records lacked evidence the licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. On June 29, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "I was unable to locate the dementia policies, but I will keep looking." No policies were provided to the surveyor by the close of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and	02170		

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02170	Continued From page 128 (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R3 and R4) who resided in the secured memory care unit. 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	02170		

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02170	Continued From page 129 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 had an assisted living with dementia care license, effective August 1, 2021. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R3 and R4's records lacked documentation of evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On June 28, 2023, at 11:22 a.m., activities coordinator (AC)-L stated, "I'm unaware of the requirements, I know we do not do any activities assessments for any of the residents." The licensee's undated Recreation/Activities policy read, "Recreational opportunities should be offered based on the interests of the residents. The assisted living statute requires that a daily program of social and recreational activities that are based upon individual and group interests,	02170		

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02170	Continued From page 130 physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large is offered. There are additional requirements for settings licensed as ALDC. Programs must be culturally sensitive." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
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 provide care and services according to acceptable health care, medical or nursing standards for two of five residents (R3, R8) with consumer bed rails and assistive devices. 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).	02310	On June 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three widespread violation.	

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02310	Continued From page 131 The findings include: R3 R3 had diagnoses to include multiple sclerosis, mild cognitive impairment of uncertain or unknown etiology, other amnesia, and unspecified mood disorder. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. On June 27, 2023, at 6:40 a.m., the surveyor observed R3's bed had one Halo Safety Ring bed rail (consumer bed rail) at the top of the bed on the side not against the wall. The bed rail was firmly attached to the bed. The surveyor also observed a chair grab bar assistive device that was secured from the ceiling to the floor on the right side of the chair and an unsecured grab bar assistive device on the left of the chair. R3 stated they used the bed rail, and the chair grab bars for positioning in bed and chair and for getting in and out of bed or chair. Unlicensed personnel (ULP)-B stated R3 utilized all the assistive devices and stated, "it helps her to try to keep some independence because she has been declining." R3's record included a Bedrail Assessment for Those Clients Who Have A Bedrail dated January 3, 2022. R3's record lacked: -Documentation the bed rail and chair grab bars were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rail and chair grab bars for areas of entrapment, stability, and correct	02310		

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02310	Continued From page 132 installation; -Assistive device assessment for the floor to ceiling grab bar; and -Assistive device assessment for the unsecured grab bar. R8 R8 had diagnoses of depression, osteoarthritis, unspecified dementia, and chronic pain. R8's unsigned Service Agreement dated February 17, 2023, indicated R8 received AM/PM cares, bathing, homemaking, escorts, laundry, and medication administration. On June 27, 2023, at 10:20 a.m., the surveyor observed R8 had a black oblong shaped consumer bed rail affixed to the top of the bed on the side not against the wall. The bed rail was not firmly attached to the bed. R8's record included a Bedrail Assessment for Those Clients Who Have A Bedrail, dated March 28, 2022, indicated R8 had no bed rails and sleeps in recliner. R8's comprehensive assessment dated May 9, 2023, lacked a bed rail assessment. R8's record lacked: -Documentation the bed rail was installed, used, and maintained per manufacturer's guidelines; and -Documentation of bed rail for areas of entrapment, stability, and correct installation. On June 26, 2023, at 2:17 p.m., licensed assisted living director (LALD)-C stated, "I asked the nurses if there were any bedrails and there are none, unless one came in over the weekend and	02310		

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02310	Continued From page 133 we have not been told about it yet." On June 27, 2023, at 10:37 a.m., (LALD)-C stated, "I did not know that [R8] had a bedrail and so I don't really know how many more we will find, like I told you yesterday, I asked my staff if we had any bedrails, and everyone told me no, so I didn't realize we had any, I thought we might have one for one guy but I looked and he doesn't have any." On June 27, 2023, at 10:37 a.m., the surveyor asked R8 if they used the bedrail to help with bed mobility and R8 stated, "oh yes." On June 27, 2023, at 10:37 a.m., the surveyor asked R8 if they slept in the recliner and R8 stated, "oh yeah, I suppose." The Food and Drug Administration (FDA) guidance A Guide to Bed Safety dated 2000, and revised April 2010, indicated 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	02310		

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02310	Continued From page 134 cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." The MDH website indicated for consumer bed rails, the licensee must include in their documentation: - 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". The licensee's Assessing the Safety Of Side Rails policy dated January 2014, indicated staff would alert the Registered Nurse (RN) if a resident had any type of bed rail or similar equipment and the RN would evaluate whether the bed rail appeared to be safe for the resident. The RN would educate the resident, their representative and/or family members about the risks related to bed rails, and if the resident's bed rails appeared not to meet FDA standards, the RN would recommend to the resident, the resident representative, or the	02310		

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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
02310	Continued From page 135 resident's family involved. TIME PERIOD FOR CORRECTION: Immediate	02310		
02480 SS=D	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the results of reviewed grievances for two of three known residents (R18, R19). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A Compliments/Concerns document dated December 14, 2023 [sic] indicated R18 was very afraid of R1 due to physical actions that occurred on July 15th of the same year and wanted to press charges for R1's actions. The rest of the document was left blank with no documented actions taken or who addressed it.	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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02480	Continued From page 136 A Compliments/Concerns document dated January 14, 2023, indicated R19 made a complaint about R1 urinating outside on chairs, spitting on the porch and that he hit R19 on the face and nicked R19's nose. The rest of the document did not have documented actions taken and by whom. A Compliments/Concerns document dated April 4, 2023, indicated R1 verbally altercated R18 at the dining room table on April 2nd and indicated the licensee hasn't "gotten rid of R1 yet." The document had registered nurse (RN)-M's signature and date, but lacked documented actions taken. A Compliments/Concerns document undated by "a concerned resident," indicated that resident was afraid of R1 because he broke the windows, raised his hand to the resident and swears all the time. On June 28, 2023, at 10:30 a.m., licensed assisted living director (LALD)-C stated the complaints were followed up with the residents in person but wasn't sure if there was documentation available. LALD-C was going to search for those documents. LALD-C did not provide any additional documents. On June 28, 2023, at 11:19 a.m., LALD-C stated the incidents mentioned before occurred before R1 was hospitalized in November of 2022, and when R1 returned to the facility, R18 and R19 submitted the complaints. LALD-C stated the residents were trying to get R1 kicked out before R1 was hospitalized. The licensee's Complaint Policy and Procedure	02480		

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02480	Continued From page 137 effective date August 1, 2021, indicated the LALD would review the complaint and determine the most appropriate staff person to investigate and follow-up and assign the complaint to that staff person and that staff person would complete the complaint investigation and follow-up and document appropriately on the complaint form. Additionally, the policy indicated complaints and resolution would be kept in the resident's record for the length of their stay at the facility. TIME PERIOD FOR CORRECTION: Seven (7) days	02480		

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21871015-0 On June 26, 2023, through June 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 54 active residents; 52 of whom received services under the Assisted Living with Dementia Care license. An immediate correction order was identified on June 27, 2023, issued for SL21871015-0, tag identification 2310. Immediate correction orders were identified on June 27, 2023, issued for SL21871015-0, tag identification 0720 and 0830. Immediate correction orders were identified on June 28, 2023, issued for SL21871015-0, tag identification 1290 and 1750.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 On June 28, 2023, the immediacy of correction order 0720 was removed, however non-compliance remained at a level two widespread violation. On June 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three widespread violation. On June 30, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three widespread violation. On June 30, 2023, the immediacy of correction order 1750 was removed, however non-compliance remained at a level three widespread violation. The immediacy of correction order 0830 was not removed at the time of exit on June 30, 2023.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health,	0 250		

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0 250	Continued From page 2 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 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	0 250		

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0 250	Continued From page 3 by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at approximately 10:53 a.m., licensed assisted living director (LALD)-C 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]:	0 250		

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0 250	Continued From page 4 - 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 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	0 250		

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0 250	Continued From page 5 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 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.	0 250		

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0 250	Continued From page 6 Page six was electronically signed by LALD-C on November 18, 2022. The licensee had an assisted living license issued on March 1, 2023, with an expiration date of February 29, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals.	0 250		

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0 250	Continued From page 7 On June 29, 2023, at approximately 1:14 p.m., registered nurse (RN)-D confirmed the licensee provided Assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0470, 0480, 0485, 0510, 0550, 0630, 0650, 0660, 0680, 0720, 0730, 0800, 0810, 0830, 0950, 0970, 1060, 1290, 1470, 1500, 1530, 1540, 1620, 1640, 1700, 1710, 1730, 1750, 1760, 1820, 1830, 1890, 1910, 1940, 1950, 2040, 2070, 2110, 2170, 2310, and 2480 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered	0 430		

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0 430	Continued From page 8 under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content to one of one resident (R4) with records reviewed. 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: R4 R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R4's signed service plan dated October 16, 2020, indicated R4 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and behavior monitoring/redirecting. On June 27, 2023, from 7:20 a.m., through 7:48	0 430		

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0 430	Continued From page 9 a.m., surveyor observed R4 receive medication administration and AM cares. On June 29, 2023, at 1:00 p.m., licensed assisted living director (LALD)-C stated they were unable to locate a UDALSA acknowledgement form for R4, and R4 and/or their representative would have signed indicating they had received it. On June 29, 2023, at 1:06 p.m. LALD-C stated, "Anybody that moved in after 144G [August 1, 2021] went into effect would have gotten the new contracts and UDALSA, but anyone who moved in prior to that would not have gotten a new one." The licensee's Uniform Checklist Disclosure of Services policy dated August 1, 2021, indicated the licensee would "Provide UDALSA to residents prior to move-in, upon move-in, or if any changes to the UDALSA are made" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly	0 470		

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0 470	Continued From page 10 and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location, potentially affecting the licensee's 54 residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at 11:15 a.m., the surveyor observed the common areas shared by residents,	0 470		

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0 470	Continued From page 11 staff, and visitors lacked the required posting of a daily staffing schedule. On June 26, 2023, at 11:18 a.m., licensed assisted living director (LALD)-C stated a posting of the daily staffing schedule should be located in the common areas. LALD-C showed the surveyor where the schedule was hung on the wall behind the reception desk. The schedule was on a clipboard and covered with a paper that read staff schedule. LALD-C stated the licensee's staff schedule was usually out where residents could see it. The staffing schedule remained covered and hung on the wall behind the reception desk for the duration of the survey. The licensee's Staffing, Direct-Care Staffing Plan & Daily schedule policy dated August 1, 2021, read, "The daily work schedule will be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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0 480	Continued From page 12 Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated June 28, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 485		

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0 485	Continued From page 13 similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to offer at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. This had the potential to affect all memory care residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On June 26, 2023, at 10:53 a.m., during entrance conference, licensed assisted living director (LALD)-C stated the licensee provided three meals per day, served per Minnesota (MN) Food Code. On June 26, 2023, at 12:08 p.m., LALD-C provided the surveyor with an undated menu titled Crestview on 42nd week 3. LALD-C stated that was the current weeks menu. The menu showed	0 485		

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0 485	Continued From page 14 that on Wednesday June 26, 2023, the residents would be offered the following; -continental [breakfast] - oatmeal/cold cereal, toast/bagel/assorted rolls. -lunch - chicken salad crossaint, potato chips, apple slices. -alternate - sandwhich of the day, soup of the day. -dinner - roasted turkey, parsley potato, mixed vegetable, fruit cocktail. LALD-C stated, "That is the only menu, it shows they can choose the soup of the day or sometimes a salad, otherwise what is listed on the menu is what we offer." The menus lacked at least three nutritious meals daily according to the recommended dietary allowances in the USDA guidelines. On June 27, 2023, at 6:52 a.m., surveyor observed unlincensed personnel offer R3 a Danish, cold cereal, and juice or tea for breakfast. No other breakfast options were available. On June 27, 2023, at 6:59 a.m., unlicensed personnel (ULP)-B stated, "This is what they send us, and we feed them what they send. They don't send fruit; I can't offer fruit." On June 27, 2023, at 11:00 a.m., surveyor observed residents eating sloppy joes, French fries and a pickle. Surveyor did not observe any fruit or vegetable with the meal. On June 27, 2023, at 4:40 p.m., R10 stated she could not digest meat, so she asked for salads but did not get them. The USDA My Plate: A Guide dated September 1, 2022, indicates half of food plates should include fruits and vegetables. Additionally, it indicated the	0 485		

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0 485	Continued From page 15 fruit group includes 100% fruit juices, however, specified at least half of the recommended amount of fruit eaten should come from whole fruit, rather than 100% fruit juice. The licensee's undated Meal Agreement reads, "The facility must offer at least three nutritious meals daily with snacks available seven days per week, in accordance with the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables, and meal substitutions must be of similar nutritional value if a resident refuses a food that is served." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 510		

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0 510	Continued From page 16 review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one unlicensed personnel ((ULP)-F) observed to provide personal cares and medication administration for multiple residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on June 27, 2023, between 11:30 a.m. and 12:12 p.m., ULP-F was setting up medications for R21 and without wearing gloves, she used her hands to pour a medication from a medication bottle and placed it into the small plastic medication cup. After medication administration with R21, ULP-F did not wash her hands. She met R8 at the front entry of the facility and gave the electronic device to R8 to hold while ULP-F propelled R8 back to her room. ULP-F performed no hand hygiene before transferring R8 from wheelchair to recliner. ULP-F proceeded to R8's kitchen to set up her medications without washing hands. After medication administration, and without washing hands, ULP-F went to R22's room, donned (applied gloves) and assisted R22 with toileting. R8 requested privacy so surveyor waited in the kitchen of R8's apartment. ULP-F came out of bathroom with R8 and proceeded to set up medications in R8's kitchen area. Surveyor	0 510		

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0 510	Continued From page 17 did not observe handwashing, but it was unknown if hand hygiene was performed within the bathroom. After ULP-F completed medication administration with R8, she proceeded to R15's room without hand hygiene. ULP-F set up R15's medication and gave it to R15, then left the room without hand hygiene. During interview on June 27, 2023, at 12:20 p.m., surveyor asked when she was trained to complete hand hygiene. ULP-F stated, "thank you for reminding me I need to wash my hands." ULP-F's undated training record included competencies on hand hygiene and hand washing. During interview on June 29, 2023, at 1:12 p.m., registered nurse (RN)-D stated infection control training should be done at new hire orientation, and staff should be signed off by an RN. For hand hygiene, staff can hand sanitize three times before they need to wash their hands. Hand washing should be performed between cares, and after doffing (removing) gloves. RN-D also stated medications should never touch bare hands, medications should be poured into the cap of the medication bottle, then poured into the medication cup. Lastly, staff needed to administer medications with their hands, they must wear gloves. The licensee's undated Infection Control Policy indicated they would follow standard and transmission-based precautions to be followed to prevent the spread of infections: -hand hygiene to be followed by staff with direct care, handling resident care equipment and the environment; -selection and use of personal protective	0 510		

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0 510	Continued From page 18 equipment (PPE) for residents and/or staff; and -PPE use appropriate to the infection or outbreak. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated July 29, 2021, effective August 1, 2021, indicated the RN would instruct staff on infection control techniques that must be followed when administering medications, treatment and therapy including hand washing and the use of gloves when appropriate. 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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 19 This MN Requirement is not met as evidenced 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on June 26, 2023, at 12:00 p.m., surveyor observed a Record of Grievance/Complaint posting did not include the contact information such as name, telephone number, and email contact information for the individual responsible for handling resident grievances. On June 29, 2023, at 3:03 p.m., registered nurse (RN)-D stated the grievance posting should have included the community contact, corporate contact, and administrators contact information. The licensee's Complaint Policy and Procedure effective August 1, 2021, indicated the written notice all residents receive would have the name and contact information of the person representing the facility designated to handle and resolve complaints. No further information was provided.	0 550		

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0 550	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of four residents (R1, R3). 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 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).	0 630		

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0 630	Continued From page 21 The findings include: R1 R1 admitted to the licensee for services on August 2, 2021. R1's diagnoses included alcohol abuse, history of depression, atrial fibrillation, and unspecified protein-calorie malnutrition. R1's IAPP dated June 2, 2022, indicated R1 did not have areas of vulnerability in behaviors posing a risk to self, alcohol abuse, and smoking. R1's record included progress notes as follows: -On March 9, 2023, at 4:05 p.m., registered nurse (RN)-M documented R1 was smoking in his room on multiple occasions, maintenance staff reported to RN-M that he walked into R1's room and witnessed him actively smoking on his bed; -March 24, 2023, at 3:16 p.m., RN-M documented R1 continued to smoke cigarettes in his room and burn incense. R1 was given an "infraction notice" again today; -March 29, 2023, at 11:26 a.m., RN-M documented that R1 was given a lease violation notice for smoking inside, burning incense, and propping main door open; -April 5, 2023, at 1:05 p.m., RN-M documented that R1 was given another lease violation letter due to smoking inside his room; -April 12, 2023, at 2:11 p.m., RN-M documented R1 was not witnessed smoking in his room that shift but RN-M could smell lingering odor. RN-M re-educated R1 on the danger to other residents as well as importance of following his no smoking lease agreement. R1 became angry on approach and denied smoking inside; -April 17, 2023, at 8:14 a.m., LPN-J documented they walked by R1's room and R1 was smoking a	0 630		

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0 630	Continued From page 22 cigarette; LPN-J told R1 he wasn't supposed to be smoking and asked to put the cigarette out, which he did; -April 18, 2023, at 7:18 a.m., LPN-J documented unlicensed personnel (ULP) reported to them that R1 was smoking in his apartment that morning; -April 20, 2023, at 1:12 p.m., RN-M documented R's1 apartment produced a strong cigarette smoke smell, so an air purifier was moved from the apartment kitchen to R1's room; -April 25, 2023, at 10:14 a.m., LPN-J documented R1 was smoking in his room and was putting it out as LPN-J entered his room; and -April May 8, 2023, at 9:57 a.m., LPN-A documented LPN-C received a call from ULP reporting R1 hit ULP in the face and grabbed her arm when she asked R1 to smoke in the designated area because residents were complaining. Police were called and a report was filed. During interview on June 27, 2023, at 1:21 p.m., RN-D stated the IAPP should have addressed the smoking, alcohol abuse, and behaviors. R3 R3 admitted to the licensee for services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's record included an IAPP which reviewed the resident's susceptibility to abuse by another individual, including other vulnerable adults and the resident's risk of abusing other vulnerable adults, however, it lacked statements of the specific measures to be taken to minimize the risk of abuse.	0 630		

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0 630	Continued From page 23 On June 28, 2023, at 11:20 a.m., licensed assisted living director (LALD)-C stated, "I took a quick look at the IAPP, and I didn't see it, so I am guessing that what you see is all that's there. I'm not sure why its missing information." The licensee's Individual Abuse Prevention Plan policy, dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each assisted living resident and the plan would contain statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 24 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-B, and licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B began employment with the licensee, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-B's employee record lacked the following documentation of required competency training completed by a registered nurse (RN): -administering medications or treatments as required.	0 650		

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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
0 650	Continued From page 25 On June 27, 2023, at 7:58 a.m., ULP-B stated, "I was trained when I was hired but that was over 20 years ago, so I don't recall what all we did. I don't remember who all trained me, but I was trained to pass medications. I follow the rights and I do all the checks." LPN-A During interview on June 29, 2023, at 8:15 a.m., licensed assisted living director (LALD)-C stated LPN-A was hired May of 2022 to work part-time. Prior to that, LPN-A worked for different facility under the umbrella of the same parent company. LPN-A's employee record lacked documentation of orientation training in the following: -overview of Assisted Living statutes; -review of provider's policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -Assisted Living bill of rights; -handling of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -orientation to each specific resident and services provided [144G.63 Subd. 3]. On June 28, 2023, at 12:26 p.m., LALD-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of	0 650		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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0 650	Continued From page 26 the employees will have everything, it just depends on which employee you pull." On June 28, 2023, at 3:35 p.m., LALD-C stated, "Let's just say I can't find her [ULP-B] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy effective date August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

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0 660	Continued From page 27 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, baseline screening and TB training for two of two employees (unlicensed personnel (ULP)-B) and (licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-C provided the facility TB risk assessment. The TB risk assessment dated April 3, 2023, indicated the licensee was low risk. ULP-B had a start date of December 4, 2002. ULP-B's employee record lacked evidence of the following: -baseline TB screening; and -TB training. LPN-A had a start date of December 9, 2005.	0 660		

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0 660	Continued From page 28 LPN-A's employee record lacked evidence of the following: -baseline TB screening. During interview on June 29, 2023, at 3:12 p.m., registered nurse (RN)-D stated, "Mantoux needs to be done and you need to do baseline screening from date of new hire and they have to get either a 2 step Mantoux or a chest X-ray or QuantiFERON and then annual screening needs to be done and they should be keeping the records, but LALD-C is having a hard time finding the records because they just don't have them. Also, the annual TB risk assessment determines risk level based on county transmission and then the screening forms themselves should be completed annually and kept in the employee file." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's TB Prevention and Control policy dated July 29, 2021, indicated the following: -education of assisted living staff and contracted staff volunteers regarding TB signs and symptoms, infection control plan and other communicable diseases; -screening of assisted living staff, and contracted staff and volunteers for TB. If {licensee} is assessed as medium risk, the screening and testing will be conducted annually. This screening will be performed by a registered nurse; and -maintain all reports of TB screening in the personnel files of assisted living employees and volunteers.	0 660		

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0 660	Continued From page 29 The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy dated July 29, 2021, indicated all employees must complete orientation to assisted living facility licensing requirements which included TB prevention and control. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 30 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Disaster Plan Policy and Procedure did not include the following required content: - community risk assessment with documentation; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); and -missing resident plan; - develop and implement EP policies/procedures and review/update annually; - subsistence needs for staff and residents during emergency situation; - develop policy and procedures for shelter in	0 680		

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0 680	Continued From page 31 place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; and - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; and - volunteers - communication plan must include contact information for: - MN Office of Ombudsman for LTC; and - other sources of assistance -Communication plan must include: -primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies - communication plan must include: - means to provide information about facility occupancy/needs; -Communication plan must include all of the following: -means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	0 680		

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0 680	Continued From page 32 designee; -Communication plan must include all of the following: -method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives The licensee's undated Disaster Plan Policy and Procedure indicated the licensee would provide guidelines for actions to those individuals responsible for the safety of the residents, tenants, staff, the visiting public and the facility itself. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 720 SS=F	144G.43 Subd. 2 Access to records The facility must ensure that the appropriate records are readily available to employees and contractors authorized to access the records. Resident records must be maintained in a manner that allows for timely access, printing, or transmission of the records. The records must be made readily available to the commissioner upon request. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that resident records were readily available for employees authorized to access the records during medication administration. This had the potential to affect all residents.	0 720	On June 28, 2023, the immediacy of correction order 0720 was removed, however non-compliance remained at a level two widespread violation.	

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0 720	Continued From page 33 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 entrance conference on June 26, 2023, at approximately 10:30 a.m., licensed practical nurse (LPN)-A stated the licensee provided medication administration to the residents. The licensee utilized an electronic device to access the medication administration record (MAR) for each staff person administering medications. LPN-C also indicated each resident's medications were stored within their apartment in a locked box inside of a cabinet. During observation on June 27, 2023, at 10:15 a.m., unlicensed personnel (ULP)-G entered a resident's room and had an electronic device without access to the MAR due to internet issues. ULP-G stated she went downstairs to check the MAR before coming upstairs to set up the medication. ULP-G administered the medication and left the room. During observation on June 27, 2023, between 11:30 a.m. and 12:12 p.m., ULP-F set up and administered medications for four residents and three of those four residents' apartments did not have internet access. ULP-F proceeded to set up medications without access to the MAR for three of those residents.	0 720		

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0 720	Continued From page 34 During interview on June 27, 2023, at 11:30 a.m., ULP-F stated at the beginning of every shift, she checks the MAR located in the nursing office for any changes in resident medications. She stated sometimes she would write them down on paper. ULP-F also stated she had been working with these residents for a very long time and she "knows them." During interview on June 27, 2023, at 2:09 p.m., licensed assisted living director (LALD)-C stated the internet issue was brought to her attention about four months ago and she was currently working with information technology (IT) to fix it. During interview on June 27, 2023, at 2:10 p.m., ULP-F stated the internet had always been "spotty," but it became a real issue about six months ago. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, stated unlicensed personnel would complete procedure for checking the {resident's} MAR and medication profile. Additionally, medications must be administered according to the "6 rights:" -right person, -right medication, treatment or therapy, -right time, -right route, -right dose, and -right chart/record to document that the medication, treatment and therapy was given No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 720		

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0 730	Continued From page 35	0 730		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 36 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of two discharged residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 admitted for services on September 20, 2019, and discharged to a transitional care unit (TCU) on January 24, 2023. R2's record lacked a discharge summary. On June 27, 2023, at 1:15 p.m., registered nurse (RN)-D stated, "looking through the past discharges the previous nurse was not doing actual discharge summaries for anyone."	0 730		

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0 730	Continued From page 37 The licensee's Discharge Summary policy, dated August 1, 2021 indicated a discharge summary would be written by the time of discharge and would include if applicable, the diagnosis, courses of illness, allergies, treatments, therapies, pertinent lab results, pertinent radiology results, pertinent consultation results, and final summary of the resident's status including baseline and current mental, behavioral and functional status. No further information provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 38 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 June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45 a.m. During the tour, survey staff observed the following: -The memory care courtyard gate was blocked from the outside by a parked white vehicle preventing proper exiting to a public way. The gate partially opened from the inside but failed to open completely due to the vehicle obstruction of the gate for exiting. The DOM-I and M-K asked the staff to relocate the vehicle. -The memory care courtyard walkways had shrubs/landscapes obstructing the walkways to the public way. The finding was evident as the exit doors inside of the building showed signs to exit or evacuate into the courtyard. Survey staff discussed with the DOM-I that all exit discharge walks and exterior walkways serving marked exit doors through the courtyards must be continuously maintained (and seasons) for safe means of egress to the roadway during an emergency. -A large tree limb was observed overhanging the walkways located between the tree and the roof gutter in the courtyard and poses a safety concern of falling onto resident(s). -The memory care laundry room had plumbing	0 800		

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0 800	Continued From page 39 fixtures that were no longer used (abandoned) but not properly disconnected or capped to prevent sewer gas entry into the building environment. The DOM-I confirmed and explained the plumbing fixtures were no longer used for many years. -The patio near the dining room had uneven concrete pad surfaces (over ½ inch) creating tripping and unsafe resident use of the patio as residents shuffle when walking. In addition, the dining room had an exit sign that discharged into the patio during an emergency and must be maintained for safe means of egress to the roadway. -Obstructions in the means of passageway and egress were observed in the memory care corridor near room 121 with tables/chairs placement, storage of mobility scooter in the corridor near room 321, and storage on the 3rd-floor stairway refuge area (located between rooms 318/320). -The back building sidewalk/walkway linking to the dining room patio had wood-constructed guardrails that were not maintained as the wood guardrails were not secured and worn out. -The sidewalks in front of the building connecting to the public way were damaged and had uneven surfaces ranging from 1 to 2 inches in size preventing safe means of egress to the roadway. In addition, the uneven and broken surfaces create safety concerns for wheelchair residents. -The 1st-floor kitchen exit door hardware was not maintained as required for proper egress, failed to latch when closed, and the door handle when turned in the downward position to exit failed to open. Upon further investigation, the door handle only opened the door in the upward position when survey staff attempted to open it again. Survey staff explained to the DOM-I that the hardware for the door must function in a manner that special	0 800		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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0 800	Continued From page 40 knowledge must not be necessary or required for safe egress. -The fire-rated door for the laundry room (3rd floor) failed to positively latch when closed which compromised the fire safety of the corridor. -The fire-rated stairway door near the chapel area failed to positively latch when closed to properly protect and maintain the integrity of the vertical stairway enclosure in the means of egress. -The room carpet flooring inside resident rooms 203, 212E, and 212W were soiled and stained. -Unlabeled multi-adapter was improperly used in resident apartment room 216 with medical equipment (oxygen) plugged into the adapter. Survey staff explained to the DOM-I and the M-K that medical equipment must directly be plugged into a dedicated power outlet. In addition, the use of unlisted and unlabeled extension cords/adapters poses a potential electrical fire hazard from overloading the electrical circuits and is a safety concern to residents. Extension cords must be listed and labeled to UL 817. Extension cords must be listed and labeled to UL 817. Multi-plug adapters must be listed to UL 498A. -Inside the common living area in resident room 301 near 301W), survey staff observed boxes and personal items on the floor restricting an adequate and proper egress path exit the apartment door for safe egress during an emergency resident 301W. -Smoke alarms were not secured to the ceiling brackets and were observed hanging from the ceiling in resident rooms 103, 115, and 312. All listed findings and/or observations were visually and/or verbally verified by the DOM-I and the M-K accompanying the tour. On June 29, 2023, at approximately 2:15 p.m., during the exit interview, the LALD-C, the DOM-I,	0 800		

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0 800	Continued From page 41 and the M-K acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 42 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 observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff and residents on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. 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 June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45 a.m. On June 29, 2023, at approximately 1:15 p.m., the LALD-C and the DOM-I provided survey staff with the available facility fire safety and evacuation plan and related documentation for review. At approximately 2:00 p.m., document review and interview with the LALD-C, the DOM-I, and the M-K indicated the following:	0 810		

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0 810	Continued From page 43 -Document review indicated that the facility's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique resident situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation, and must be addressed in the fire safety and evacuation plan documentation. -Document review indicated that the fire safety and evacuation plan lacked fire protection procedures for residents. -Document review indicated that the licensee lacks a record of employee training specifically on the fire safety and evacuation plan. The minimum required annual employee training must be twice a year for fire safety and evacuation after new employee orientation. Survey staff received employee training records on fire safety and evacuation plan for December 2022 as part of the licensee's annual emergency preparedness training. No other record was available or provided for review. -Document review indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During the interview, the LALD-C indicated they had no records to support the training. -Record review indicated the licensee failed to perform the minimum required frequency of evacuation fire drills. Three fire evacuation drill records were provided for review, two ddrills were	0 810		

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0 810	Continued From page 44 performed in 2022 (9/30/2022 1:40 p.m. and 11/9/2022 2:00 a.m.), and one drill in 2023 (6/26/2023 6:45 p.m.). Survey staff explained that evacuation drills must be performed twice per year per shift with at least one evacuation drill every other month frequency. During the interview, the LALD-C and the DOM-I verified that the fire safety and evacuation plan for the facility lacked these provisions. On June 29, 2023, at approximately 2:15 p.m., during the exit interview, the LALD-C, the DOM-I, and the M-K acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). 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,	0 830		

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0 830	Continued From page 45 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 the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at 10:00 a.m., the surveyor entered the second floor and smelled a strong cigarette smoke odor coming from apartment 212 that infiltrated the entire second floor hallway. R1 R1 admitted to the facility on August 2, 2021. R1's diagnoses included alcohol abuse, atrial fibrillation, and unspecified protein-calorie malnutrition. R1's Task List Report dated June 27, 2023, indicated R1 received medication administration by unlicensed personnel (ULP) and twice a day safety checks. R1's last comprehensive assessment dated June 2, 2022, indicated under smoking assessment, that R1 had the ability to smoke without causing burns or injury, and no interventions were needed. R1's smoking assessment also indicated that staff were to do safety checks with resident on each shift due to poor decision making while intoxicated. During observation on June 27, 2023, at 10:30 a.m., surveyor entered R1's apartment which is shared with another resident (common kitchen and bathroom). R1 was sitting on his/her bed and surveyor noted the only window in the bedroom	0 830		

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0 830	Continued From page 46 opened approximately 9 inches. Surveyor observed a trash can near the bed with ashes and numerous discarded cigarette butts. Surveyor asked R1 if s/he smoked in the room and R1 said "sometimes." R1 then became agitated and asked surveyor to drop the subject and stated s/he was going to go outside and smoke. R1 then left the apartment. Throughout the survey, numerous staff and residents complained about R1's smoking to the surveyors. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 830		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 47 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 execute a written assisted living contract with all required content for two of four residents (R3, R4). 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	0 950		

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0 950	Continued From page 48 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: R3 R3's Resident Agreement was signed on September 6, 2019. R3's Resident Agreement on page 2 of 15 read, -Your Designated Representative. You have designated the person or persons listed as Your Designated Representative on Page 2 of the Summary, if any, to be involved on Your behalf with respect to this Agreement, and has presented Us with documentation about authority, a copy of which is attached. The duties and obligations of Your Designated Representative are to assist You in fulfilling Your financial obligations under this Agreement in full and on time, to assist You to comply with the terms of this Agreement in other respects, and to otherwise assist You while you are a resident at [licensee]. R4 R4's Resident Agreement was signed on March 8, 2012. R4's Resident Agreement on page one read, IF APPLICABLE: You have designated XXX as your Designated Representative to assist you with any matters related to this Residency Agreement. R3 and R4's Resident Agreement lacked the designate a representative verbatim "right to designate a representative for certain purposes" notice.	0 950		

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0 950	Continued From page 49 On June 29, 2023, at 1:06 p.m., licensed assisted living director (LALD)-C stated, "Anybody that moved in after 144G [regulations] went into effect would have gotten the new contracts and Uniform Disclosure of Assisted Living Services & Amenities (UDALSA), but anyone who moved in prior to that would not have gotten a new one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	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 contract did not include language waiving the licensee'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	0 970		

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0 970	Continued From page 50 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 R3's signed assisted living contract read, -Your Personal Property; No Liability of Management. "Management has no responsibility to You or any third party for any personal property placed in the Apartment or in any other location within Crest View on 42nd by You or the owner of such personal property. Management is not responsible to You or any third party for loss of any personal property by theft or any other cause. You assume all risk for harm to or loss of any of Your personal property, and release, indemnify, defend, and hold Management harmless from any and all liability with respect to harm to or loss of any of Your personal property." - No Liability of Management for Certain Other Losses or Damages. "You acknowledge familiarity with the Apartment, the premises and services of Crest View on 42nd and are therefore willing to, and do, assume all risk associated with occupancy. You further acknowledge that Management is not an insurer of Your safety. Management, its employees, and its agents are not liable to You or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by You or any other person, for any loss or damage to property, that is not a direct result of intentional or neglect acts in violation of applicable standards of care. For example, Management is not liable to You for any injury, loss, or damage to any property or person, whether caused by fire, explosion, leakage, seepage, bursting, deluge, or overflow of water or	0 970		

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0 970	Continued From page 51 sewage or damage occasioned by water, or for any damage arising from acts or negligence of other tenants, or for any loss of any articles by theft, vandalism or any other cause." R4 R4's signed assisted living contract read, -Your Personal Property; No Liability of [licensee]. "We have no responsibility to You or any third party for any personal property placed on the premises by You or the owner of such personal property. We are not responsible to You or any third party for loss of any personal property by theft or any other cause." - No Liability of [licensee] for Losses or Damages. "You acknowledge familiarity with the apartment, the premises and services of Crest View on 42nd and therefore are willing to assume all risks associated with the occupancy. You further acknowledge that We are not an insurer of Your safety. Crest View on 42nd, its employees, and its agents are not liable to You or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by You or any other person, or any loss or damage to property, unless directly caused by Us as a result of intentional or negligent acts. We are not responsible for the actions of, or for any damages, injury or harm caused by, third parties (such as other residents, guests, intruders, or trespassers) who are not under Our control." On June 29, 2023, at 1:06 p.m., licensed assisted living director (LALD)-C acknowledged that R3 and R4's contract contained waivers of liability language and stated, "Anybody that moved in after 144G [regulations] went into effect would have gotten the new contracts and Uniform Disclosure of Assisted Living Services &	0 970		

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0 970	Continued From page 52 Amenities (UDALSA), but anyone who moved in prior to that would not have gotten a new one." The licensee's updated contract dated August 2022 did not contain waivers of liability language. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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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
01060	Continued From page 53 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative 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) 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 admitted to licensee on August 2, 2021. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., indicated unlicensed personnel (ULP)-F was alerted R1 was on the ground	01060		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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01060	Continued From page 54 outside. ULP-F informed kitchen staff person to contact 911. R1 was taken to Unity Hospital to be evaluated. R1's Progress Notes dated November 7, 2022, at 9:36 a.m., written by licensed practical nurse (LPN)-J indicated R1 was extremely intoxicated on Sunday and fell twice in front of the building. LPN-J received a call from a social worker at Unity Hospital informing LPN-J that R1 fractured his hip and Unity Hospital would transport R1 to Mercy Hospital. R1's Progress Note dated December 12, 2022, at 1:11 p.m., written by registered nurse (RN)-M indicated R1 still remained at the hospital and an assessment would be completed upon return. R1's record lacked a written notice with the required statutory content provided to resident or resident representative of emergency relocation. R1's record lacked documentation a notice was sent to the Office of Ombudsman for Long-Term Care (OOLTC) when R1 did not return to the facility within four days. On June 29, 2023, at 1:14 p.m., RN-D stated, "They don't have the emergency relocation form, they don't even know what it is, so I will send it to them, I have it for the other site." RN-D, a contracted nurse working for another licensee under the same company, was temporarily filling in for RN-M while on leave of absence. On June 29, 2023, at 3:16 p.m., licensed assisted living director (LALD)-C provided a blank Notice of Emergency Relocation document via email. The licensee's undated Emergency Relocation	01060		

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01060	Continued From page 55 document indicated the licensee would deliver a written notice to the resident, their legal representative and their designated representative. It also indicated a notice must be delivered to the OOLTC if the resident has not returned within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-B).	01290	On June 30, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three widespread violation.	

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01290	Continued From page 56 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: ULP-B ULP-B began employment with the licensee, under the former comprehensive license and started providing assisted living services August 1, 2021. On June 27, 2023, at 7:20 a.m., the surveyor observed ULP-B administer oral medications to R4. ULP-B's employee record contained a background study dated December 29, 2002. ULP-B's record lacked evidence the licensee submitted a background study for ULP-B under the current assisted living with dementia care license and affiliated to the current HFID number. On June 28, 2023, at 12:58 p.m., LALD-C acknowledged ULP-B's background study was in progress, and LALD-C was unsure how many other staff would need an updated background study and stated, "I would have to check to see who all still needs a background study, I am unsure at this point." On June 28, 2023, at 12:22 p.m., the evaluator observed Minnesota Department of Human Services NETStudy2.0 which indicated ULP-B	01290		

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01290	Continued From page 57 had a background study that was in process for the HFID associated with the licensee. The licensee's Background Checks policy dated August1, 2021, read, "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. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 58 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: (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 staff providing services completed an orientation to	01470		

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01470	Continued From page 59 assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-F, and licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's residents. On June 27, 2023, from 7:20 a.m., through 7:48 a.m., surveyor observed ULP-B provide medication administration and AM cares to R4, while training a newly hired ULP. ULP-B's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -overview of assisted living statutes; -review of provider's policies and procedures -reporting maltreatment of vulnerable adults or minors; -assisted Living bill of rights; -handing of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of assisted living services the	01470		

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01470	Continued From page 60 employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -initial 8 hours of dementia care training. On June 27, 2023, at 7:58 a.m., ULP-B stated, "I was trained when I was hired but that was over 20 years ago, so I don't recall what all we did." On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. On June 27, 2023, from 11:30 a.m. to 12:12 p.m., surveyor observed ULP-F provide medication administration for four residents and cares to two residents. ULP-F's record lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of the appropriate Assisted Living statutes and rules; -handling of emergencies and use of emergency services; - assisted living bill of rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report; - consumer advocacy services;	01470		

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01470	Continued From page 61 - review of the types of assisted living services the employee will provide and provider's scope of license; - orientation to each specific resident and services provided; and - dementia training required for all direct care staff and supervisors. LPN-A LPN-A was hired May of 2022 per LALD-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LALD-C did not provide the exact date of hire. During the survey from June 26, 2023, through June 29, 2023, surveyor observed LPN-A perform tasks such as medication set-up, medication deliveries, interactions with various residents and performing nursing duties within the nursing office. LPN-A's record lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of the appropriate Assisted Living statutes and rules; - review of provider's policies and procedures; - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report; - consumer advocacy services; - review of the types of assisted living services the employee will provide and provider's scope of	01470		

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01470	Continued From page 62 license; - orientation to each specific resident and services provided; and - dementia training required for all direct care staff and supervisors. LPN-A's training record transcript dated November 7, 2022, indicated LPN-A completed five point five (5.5) hours out of the required eight hours. On June 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 29, 2023, at 3:10 p.m., the registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not done." The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy dated August 1, 2021, indicated the above items	01470		

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01470	Continued From page 63 would be trained on and the policy read, "All assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 64 disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-B and ULP-F, licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a	01500		

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01500	Continued From page 65 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: ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's residents. ULP-B's record lacked evidence annual training had been completed as required in the following areas: - reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; - infection control techniques; - effective approaches to use to problem solve when working with resident's challenging behaviors; - review of provider's policies and procedures; and, - principles of person-centered planning/service delivery. ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. ULP-F's record lacked evidence annual training had been completed as required in the following areas: - Assisted Living bill of rights;	01500		

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01500	Continued From page 66 - infection control techniques; - effective approaches to use to problem solve when working with resident's challenging behaviors; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. LPN-A LPN-A was hired May of 2022 per licensed assisted living director (LALD)-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LPN-A's record lacked evidence annual training had been completed as required in the following areas: - Assisted Living bill of rights; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." On June 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull."	01500		

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01500	Continued From page 67 On June 29, 2023, at 3:10 p.m., the registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." The licensee's Assisted Living with Memory Care Annual Training policy dated August 1, 2021, indicated, all assisted living employees would complete annual education on the above-mentioned items, direct-care staff will complete 8 hours of annual training for each 12 months of employment, and annual training would be documented in accordance with the documentation policy. Although requested by the surveyor, the licensee provided no dementia training policies by the close of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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01530	Continued From page 68 (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 interview and record review the licensee failed to provide evidence of annual dementia care training on required topics for one of one employee (licensed practical nurse (LPN)-J). 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	01530		

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01530	Continued From page 69 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective March 1, 2023, through February 29, 2024. LPN-J was hired on June 15, 2015, to provide supervision and oversite to unlicensed personnel and provide direct services residents. LPN-J was a full-time employee and worked Monday through Friday. LPN-J's employee records contained seven reading pages describing myths and facts pertaining to dementia, information on delirium, as well as a ten question quiz on dementia. LPN-J's records lacked any documentation that the annual dementia care training requirements had been completed. On June 29, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "With [LPN-J's] annual training, I was able to find what they [licensee's educator] went over and the quizzes but there is nothing I have that shows how much time the dementia training took, just those few sheets of paper on what was covered." On June 29, 2023, at 3:10 p.m., registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required	01530		

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01530	Continued From page 70 training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." Although requested by the surveyor, the licensee provided no dementia training policies by the close of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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;	01540		

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01540	Continued From page 71 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the employment start date for three of three employees (unlicensed personnel (ULP-B), ULP-F, licensed practical nurse (LPN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective March 1, 2023, through February 29, 2024. ULP-B ULP-B was hired on December 4, 2002, to perform direct care services to the licensee's residents. ULP-B's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date. ULP-B's General Orientation Checklist For New Employees dated December 2002, included "dementia care training (for direct care staff and supervisors if the agency serves clients with dementia)", but did not specify number of hours.	01540		

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01540	Continued From page 72 On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." ULP-F ULP-F was hired on December 17, 2021, to perform direct care services to the licensee's residents. ULP-F's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date. ULP-F's training record dated December 28, 2021, included "elderly-age, diagnoses, dementia specific care," and "additional dementia/ hospice," but did not specify number of hours. ULP-F's Individual Training Record-2021 dated December 28, 2021, indicated ULP-F received general orientation-1.5 hours and skills with a staff person-3 hours. Dementia training was left blank. LPN-A LPN-A was hired May of 2022 per licensed assisted living director (LALD)-C. LALD-C stated LPN-A works half the time at licensee and the other half at a facility under a different license, but within the same organization. LPN-A's training log record dated December 5, 2022, indicated LPN-A completed 5.5 hours of dementia training within 80 working hours of the employment start date. On June 28, 2023, at 12:26 p.m., licensed	01540		

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01540	Continued From page 73 assisted living director (LALD)-C stated, "I have sent you everything I have been given, that is all I have without going over there myself and digging through the file myself, this is all we have." When asked if this would be the case for all employees LALD stated, "I am sure some of the employees will have everything, it just depends on which employee you pull." On June 29, 2023, at 3:10 p.m., registered nurse (RN)-D stated, "For annual training and orientation training they [staff] should be doing the health care academy [licensee's computer training program]. The educator should be able to print individual report files to prove that training was done for each staff. But the annual required training and orientation should be able to show the staff were educated on infection control, dementia, statutes training the bill of rights, VA's, person centered care, all that stuff that is required under the regulations and they should all be electronically documented or documented someway to show training was complete, because if it's not documented then it's not done." Although requested by the surveyor, the licensee provided no dementia training policies by the close of the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	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	01620		

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01620	Continued From page 74 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted assessments within 14-days following a residents admission date and ongoing nursing assessments not to exceed every 90-days thereafter for four of five residents (R1, R5, R3 and R4). In addition, licensee failed to complete a change in condition assessment for one of one resident (R1) after a hospitalization. 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	01620		

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01620	Continued From page 75 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: CHANGE IN CONDITION R1 was admitted to the licensee and began receiving services on August 2, 2021. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., written by ULP-F indicated R1 was found on the ground outside. R1 was taken to Unity Hospital to be evaluated and later admitted to Mercy Hospital due to a hip fracture. During interview on June 29, 2023, at 10:25 a.m., licensed assisted living director (LALD)-C stated R1 was admitted to the transitional care unit (TCU) on November 11, 2022, and returned to licensee on January 12, 2023. R1's record lacked a change in condition assessment upon R1's return on January 12, 2023. R1's most recent RN comprehensive assessment completed was on June 2, 2022. RN ASSESSMENT R3 R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's record lacked timely 90-day nursing assessments. R3 had AL Assessments dated October 17, 2022, January 30, 2023, and the most recent assessment was March 16, 2023. R4 R4 was admitted to the licensee and began	01620		

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01620	Continued From page 76 receiving services on March 10, 2012. R4's record lacked timely 90-day nursing assessments. R4 had AL Assessments dated August 3, 2022, December 14, 2022, and the most recent assessment was March 16, 2023. R5 R5 was admitted to the licensee and began receiving services on November 30, 2022. R5's record lacked timely 90-day nursing assessments. R5's most recent RN comprehensive assessment was dated March 13, 2023. On June 26, 2023, at 10:43 a.m., during the entrance conference, licensed assisted living director (LALD)-C identified the RN is responsible for completion of documentation and assessments of residents residing in the facility. Licensed practical nurse (LPN)-J indicated licensee's expectation were: -an initial assessment upon admission, another within 14 days of the initial assessment, every 90 days, or with any change of condition. On June 29, 3:03 p.m., RN-D stated for a hospital return, she would expect in the resident's chart, a full nursing assessment completed, any changes to the service plan with approval by resident, and documentation in progress notes. On June 29, 2023, at 3:18 p.m., RN-D stated, "Ideally you do them [90-day assessments] on the 87th day because at 91 days they are late. I think that's a fair statement when I say that they [licensee's nurses] need to print a roster and start to do assessments. They all need to be done so they are up to date."	01620		

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01620	Continued From page 77 The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy, dated August 1, 2021, read "A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 78 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a service plan in place documenting agreement on the services to be provided for one of five residents (R5). The licensee also failed to ensure service plans included signatures or other authentication by the residents and the licensee to document agreement on the change of services to be provided 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) 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: R5 R5 began receiving assisted living services on November 30, 2022. R5's record lacked a signed service plan. On June 29, 2023, at 12:56 p.m., surveyor requested R5's signed service plan from admission and licensed assisted living director	01640		

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01640	Continued From page 79 (LALD)-C stated she did not have one to provide. R5's Task List Report printed June 30, 2023, indicated R5 received weekly medication set up, daily homemaking, daily linen, and the following are on an as needed basis: pull cord, shower assistance, escorts, laboratory coordination, and additional services by ULP. R1 R1 was admitted to the licensee on August 2, 2021. R1's signed service plan dated August 2, 2021, indicated R1 would receive monthly vital signs checks (blood pressure, heartrate, respiration, oxygen level and temperature) and weight check, care coordination (help with appointment set up and transportation) as needed, telehealth visits as needed, pull cord response as needed and Coronavirus vital sign checks twice a day. R1's RN Comprehensive Assessments dated November 26, 2021, March 2, 2022, June 2, 2022, and August 8, 2022, indicated R1 was assessed to receive medication management, and weekly housekeeping services. R1's record included a service plan which was not dated nor signed by resident or the licensee agreeing to add medication administration by unlicensed personnel and weekly medication setup by a licensed nurse. R1's task record dated June 1, 2023, through June 30, 2023, indicated staff were documenting medication administration. On June 29, 2023, RN-D stated if a change was made to the service plan, it should be printed,	01640		

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01640	Continued From page 80 signed by resident or family, and included in the resident's chart. The licensee's Residency Agreement Attachment D-Service Plan dated August 2022, indicated a written service plan must include: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences. The document also indicated the initial service plan, and each revision must be signed by both the resident and an authorized representative of the provider. TIME PERIOD TO CORRECT: Seven (7) days	01640		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others	01700		

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01700	Continued From page 81 who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that based on the assessment, the registered nurse (RN) determined what medication management services would be provided, and how the services would be provided for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. R5's service agreement was requested, but not received. R5's prescriber orders, signed November 25,	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

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01700	Continued From page 82 2022, included one anxiety medication, two inhalers, two nebulizer medications, one nasal spray, one cholesterol medication, two diabetic medications, one sleep aid, one pain medication, and one blood pressure medication. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's [Licensee] Home Care Medication Assessment dated November 30, 2022, assessed R5 could self-administer her medications and medications would be stored within R5's apartment and managed by R5. R5's assessment indicated R5 would need medication reminders, and indicated, "resident wishes to control her own medications." Under additional comments, RN indicated staff to monitor and ensure safety. R5's assessment lacked evidence the RN had determined what medication management services would be provided, and how the services would be provided for R5. R5's assessment also lacked evidence of assessment on administering subcutaneous injections. R5's Task List Report printed June 30, 2023, indicated R5 received weekly scheduled medication set up by placing medications into specific containers and delivered to the room. RN to assess medication compliance, observation of drug interactions and responses to medications. R5's Medication Administration Record (MAR) dated June 1, 2023, through June 30, 2023, listed the medications R5 was ordered to take scheduled at various times at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m., and as needed (PRN). The following medications on the MAR indicated	01700		

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01700	Continued From page 83 "U-SA" (unsupervised self-administration): -trazodone 50 milligram (mg) ½ tablet daily for sleep; -hydrochlorothiazide 12.5 mg-1 tablet daily for high blood pressure; -fluticasone Furoate 50 microgram (mcg)-inhale 1 orally daily for COPD; -aspirin 81 mg-1 tablet daily to thin blood; -atorvastatin calcium 40 mg-1 tablet daily for high cholesterol; -celecoxib 200 mg-1 capsule daily for swelling; -clotrimazole cream 1%-apply to affected area topically twice a day for rash; -eye vitamins-2 capsules daily to supplement; -humulin 70/30 suspension 100 unit/milliliters (ml)-inject 20 units subcutaneously twice a day for diabetes; -hydrocortisone ointment 1%-apply to affected areas topically two times a day for dermatitis; -lisinopril 40 mg-1 tablet daily for high blood pressure; -omeprazole 20 mg-1 capsule daily for stomach; -albuterol sulfate 108 mcg- inhale two puffs four time a day for shortness of breath; -albuterol sulfate 108 mcg-inhale two puffs every 6 hours for shortness of breath; and -triamcinolone acetonide external cream 0.1%-apply to skin topically two times a day for rash The following medications on the MAR were documented by staff on various shifts and various days of the month: -buspirone 5 mg-1 tablet twice a day for anxiety on 23 scheduled times between June1 through June 27, 2023-6 of those documented "drug refused," and 5 of those documented, "other/ see nurse notes." Twenty-nine scheduled times were left blank; -buspirone 10 mg- tablet twice a day for anxiety	01700		

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01700	Continued From page 84 on two scheduled times between June 27 through June 30, 2023-one documented, "other/ see nurse notes." Four scheduled times were left blank; -metformin 500 mg-two tablets twice a day for diabetes on 23 scheduled times for June 1 through June 30, 2023-6 of those documented, "drug refused." Four of those documented, "other/ see nurse notes." Thirty-seven scheduled times were left blank. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. R5 stated she received assistance with housekeeping. When surveyor asked if she was assessed by an RN after admission, she stated, "not that I remember." R5 stated a nurse from a homecare agency assisted her on a routine basis. Surveyor observed on top of the refrigerator two boxes containing daily medications in plastic pouches labeled date and time and contents of the medications. Behind those boxes were bubble cards of medications stacked behind the boxes of medications. During interview on June 29, 2023, at 2:54 p.m., unlicensed personnel (ULP)-N stated R5 provided her with blood glucose results, but she didn't know why she charted that she administered R5's medications. During interview on June 29, 2023, at 3:03 p.m., RN-D stated if there were blank spots on the MAR, it meant the medication was not given or was not documented. RN-D stated when an ULP logs out of the electronic health record, it would prompt the ULP to complete charting. RN-D stated blanks on the MAR would be considered a	01700		

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01700	Continued From page 85 medication error. If a medication error occurred, RN would re-educate ULP and go over the medication error policy with ULP. The licensee's Medication Management Services policy dated April 24, 2023, indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and would develop specific procedures that staff would provide. The director of nursing would assure that unlicensed personnel are trained, competent and oriented to the resident whenever unlicensed personnel are to perform medication management services for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment on the resident's medication management	01710		

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01710	Continued From page 86 services after a change in condition for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on August 2, 2021, with diagnoses that included alcohol abuse, protein-calorie malnutrition, and atrial fibrillation (irregular heartrate). R1's Service Plan signed August 2, 2021, indicated R1 received monthly vital sign checks (blood pressure, temperature, weight, oxygen level, respiration count and heart rate), as needed (PRN) care coordination including appointment arrangement and transportation, PRN telehealth visits, PRN call button response, and scheduled vital sign checks twice a day related to Coronavirus. R1's RN Comprehensive Assessment dated November 26, 2021, assessed R1 to receive medication management services to include medication administration by staff, and RN to monitor weekly for accuracy, availability, and compliance. R1's RN Comprehensive Assessment dated August 8, 2022, did not include all contents of the uniform assessment tool requirements of	01710		

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01710	Continued From page 87 Minnesota Rule 4659.0150. The assessment did not indicate whether there was a change to R1's medications but it did indicate R1 was taking two vitamins. R1's physician orders dated July 23, 2021, ordered R1 to take Thamine 100 milligram (mg) daily for malnutrition/alcohol abuse and folic acid 1 mg tablet-1 tablet daily for malnutrition, alcohol abuse. R1's Progress Notes dated November 6, 2022, at 11:14 a.m., ULP-F indicated R1 was found on the ground outside. ULP-F and a kitchen staff person went to assist R1 off the ground. R1 refused to come inside the building so staff went back inside. Fifteen minutes later R1 fell again outside. Witnesses saw R1 throw away an empty liter bottle of whiskey. R1 was taken to Unity Hospital to be evaluated. R1's Progress Notes dated November 7, 2023, at 9:36 a.m., indicated LPN-J was informed by a social worker at Unity Hospital that R1 fractured his hip and was being relocated to Mercy Hospital. R1's Progress Notes dated December 12, 2022, RN-M indicated R1 remained hospitalized, and an assessment would be completed upon return. R1's record lacked evidence of his return from the hospital. During interview on June 29, 2023, at 10:25 a.m., licensed assisted living director (LALD)-C indicated R1 was admitted to the transitional care unit (TCU) on November 11, 2022, and returned to licensee on January 12, 2023.	01710		

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01710	Continued From page 88 R1's Medication Administration Record (MAR) dated December 1, 2023, through December 31, 2023, indicated the following: -folic acid 1 mg tablet-1 tablet by mouth once daily at 8:00 a.m. From December 1, through December 31, there was no documentation folic acid was given; and -thiamine 100 mg tablet-1 tablet by mouth once daily at 8:00 a.m. Areas for staff to document administration were documented with "H." According to the MAR chart code, "H" meant "on hold by physician." R1's MAR dated January 1, 2023, through January 31, 2023, indicated the following: -folic acid (same as above), indicated it was given by staff on January 19, 24, 25, 27, and 30; -thiamine (same as above), was documented with an "H." R1's MAR dated June 1, 2023, through June 30, 2023, did not indicate any medications were scheduled. R1's service documentation record June 1, 2023, through June 30, 2023, indicated R1 received medication administration on June 3, 11, 14, and 26, 2023, at 8:00 a.m., while the rest of the days were left blank. R1's care plan printed on June 28, 2023, indicated R1 received the following services: medication administration by ULP, safety checks, behavioral interventions, and monthly vital sign check. R1's record lacked evidence the RN conducted an assessment for either change in condition or quarterly assessment since August 8, 2022.	01710		

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01710	Continued From page 89 R1's record lacked documentation of when licensee stopped providing medication administration to R1. R1's record also lacked an RN re-assessment to determine if R1 could self-administer his medications. On June 28, 2023, at 9:37 a.m., LPN-J stated around March of 2023, medication management services for R1 stopped. LPN-A could not explain why ULP's were documenting medication administration on R1's June 2023, MAR. On June 29, 2023, at 3:03 p.m., RN-D stated following a change in condition, the RN should have conducted a comprehensive reassessment and updated the service plan if applicable and those should be in R1's record. On June 30, 2023, at 8:10 a.m., ULP-G stated she did not administer medications for R1, it wasn't on her task list. She stated, "I don't do much for him." The licensee's Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency policy dated July 29, 2021, effective August 1, 2021, indicated the RN would reassess the resident if the resident has a change in condition. At these reassessments, the RN will: -review the resident's service plan; -evaluate the resident's medication management services and the resident's medications; -evaluate the resident's treatments, if any; -communicate any new problems or concerns to the resident's physician or health care providers, and; -update the service plan as necessary based on the resident's needs. The result of the resident monitoring visits and	01710		

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01710	Continued From page 90 reassessments would be documented by the licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	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 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	01730		

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01730	Continued From page 91 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues.	01730		

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01730	Continued From page 92 R5's service agreement was requested, but not received. R5's prescriber orders signed November 25, 2022, included one anxiety medication, two inhalers, two nebulizer medications, one nasal spray, one cholesterol medication, two diabetic medications, one sleep aid, one pain medication and one blood pressure medication. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's [Licensee] Home Care Medication Assessment dated November 30, 2022, assessed R5 could self-administer her medications and medications would be stored within R5's apartment and managed by R5. R5's assessment indicated R5 would need medication reminders, and indicated, "resident wishes to control her own medications." Under additional comments, RN indicated staff to monitor and ensure safety. R5's assessment lacked evidence the RN had determined what medication management services would be provided, and how the services would be provided for R5. R5's assessment also lacked evidence of assessment on administering subcutaneous injections. R5's Task List Report printed June 30, 2023, indicated R5 received weekly scheduled medication set up by placing medications into specific containers and delivered to the room. RN to assess medication compliance, observation of drug interactions and responses to medications. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she	01730		

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01730	Continued From page 93 managed her own medications including insulin and blood glucose checks. R5 stated she received assistance with housekeeping. When surveyor asked if she was assessed by an RN after admission, she stated, "not that I remember." R5 indicated a nurse from a homecare agency assisted her on a routine basis. Surveyor observed on top of the refrigerator two boxes containing daily medications in plastic pouches labeled date and time and contents of the medications. Behind those boxes were bubble cards of medications stacked behind the boxes of medications. On June 30, 2023, at 8:10 a.m., unlicensed personnel (ULP)-G stated R5's medications show up on the electronic medication administration record (EMAR), but nurses told her R5 does her own medications. On June 27, 2023, at 1:21 p.m., RN-D stated nursing staff would use the weekly set up service because the service included ordering of meds and monitoring of medications by nursing staff. R5's record lacked a clear and concise medication management plan to include the following required content: -a statement describing the medication management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse	01730		

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01730	Continued From page 94 or appropriate licensed health professional when a problem arises with medication management services; and -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. The licensee's Medication Management Services policy dated April 24, 2023, indicated the RN would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and would develop specific procedures that staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for 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.	01750		

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01750	Continued From page 95 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure for two of two employees (ULP-B, ULP-F). 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: ULP-B ULP-B began employment with the licensee, under the former comprehensive license and started providing assisted living services on August 1, 2021. ULP-B's employee record lacked a competency evaluation completed by a RN for medication administration. On June 27, 2023, from 6:52 a.m., until 8:40 a.m., surveyor observed ULP-B training a new hire ULP on tasks, medication administration, and services in the secured memory care.	01750	On June 30, 2023, the immediacy of correction order 1750 was removed, however non-compliance remained at a level three widespread violation.	

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01750	Continued From page 96 On June 27, 2023, at 7:20 a.m., the surveyor observed ULP-B administer oral medications to R4. ULP-F ULP-F began employment with the licensee and started providing assisted living services on December 17, 2021. ULP-F's employee record lacked a competency evaluation completed by a RN for oral medication administration. During observation and interview on June 27, 2023, at 12:12 p.m., ULP-F set up R15's scheduled noon medication and brought the medication into R15's room where she was laying on her bed. ULP-F instructed R15 to administer the medication and R15 stated "do I have to take it right now?" ULP-F stated yes, and R15 then asked ULP-F, "will this be everyday now?" After the medication administration, ULP-F admitted to surveyor that "I always set up the medication and R15 will hold it until her nap." Surveyor asked what time R15 usually took a nap and ULP-F stated 1:30 p.m. On June 27, 2023, at 8:10 a.m., ULP-B stated, "We [the ULPs] train the new people how to do the meds, that is our job, we just train each other." On June 27, 2023, at 3:35 p.m., licensed assisted living director (LALD)-C stated, "Let's just say I can't find her [ULP-B's] training and go from there, I will keep looking but so far I just don't have it, if I find it, I will get it to you." The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy	01750		

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01750	Continued From page 97 Administration dated August 1, 2021, indicated the registered nurse (RN) would instruct and competency test the ULP's in medication administration, treatment and therapy and determine the ULP to be competent to perform tasks, and the RN would document the training and competencies in the ULP's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medication was administered as prescribed for two of four residents (R3, R4), and failed to ensure that medications were administered per protocol for two of four residents (R3, R4). The licensee also failed to transcribe provider orders correctly for	01760		

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01760	Continued From page 98 one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: OMISSION R3 R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated staff did not administer the following with no reason documented: - 5:45 a.m. medications which included paroxetine hydrochloride 50 milligrams (mg), acetaminophen 1000 mg, calcium carbonate 500 mg, cetirizine hydrochloride 10 mg, cholecalciferol 125 micrograms (mcg), clonazepam 0.5 mg, Depakote sprinkles 125 mg, fiber-lax 625 mg, fluticasone propionate suspension 50 mcg, gabapentin 100 mg,	01760		

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01760	Continued From page 99 lactulose 10 gram (g)/ 15 milliliter (ml), and levothyroxine sodium tablet 75 mcg on June 2, 10, 11, 16, 24, 25 and 30; - 5:45 a.m. medications which included Aspercreme Lidocaine external cream 4 percent (%), and Baclofen oral tablet 5 mg on June 10, 11, 16, 24, 25 and 30; - 12:00 p.m. medications which included acetaminophen 1000 mg and gabapentin 100 mg on June 1,6, 8, 13, 20, 22, 27 and 29; - 12:00 p.m. medications which included Baclofen oral tablet 5 mg on June 8, 13, 20, 22, 27 and 29; and - 8:00 p.m. medications which included acetaminophen 1000 mg, Aspercreme Lidocaine external cream 4%, Baclofen oral tablet 5 mg, calcium carbonate 500 mg, clonazepam 0.5 mg, Depakote sprinkles 125 mg, and gabapentin 100 mg on June 18, 19 and 21. R4 R4 was admitted to the licensee and began receiving services on March 10, 2012. R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R4's signed service plan dated October 16, 2020, indicated R4 received services including AM/PM cares, weekly shower, laundry, medication administration, toileting, and behavior monitoring/redirection. R4's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated staff did not administer the following with no reason documented: - 4:00 p.m. medications which included acetaminophen 650 mg on June 1 on June 18, 19	01760		

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01760	Continued From page 100 and 21; - 8:00 p.m. medications which included metronidazole cream 0.75%, mirtazapine 7.5 mg, Depakote ER 250 mg, memantine hydrochloride 5mg, metoprolol tartrate 25mg, olanzapine 5mg, ProAir inhalation aerosol solution 108 mcg, Systane balance solution 1 drop, acetaminophen 650 mg, on June 18, 19 and 21; and - 8:00 p.m. medications which included Aquaphor ointment, Budesonide suspension 1mg/2ml, petroleum jelly gel, on June 2, 18, 19 and 21. ADMINISTRATION PROTOCOL ERROR R3 During observation on June 28, 2023, at 12:42 p.m., surveyors observed R3 sitting at the dining room table in the locked memory care unit eating her meal with a plastic clear medication cup with medications in it next to R3 on the table. Surveyor observed unlicensed personnel (ULP)-N sitting in a chair on the other side of the dining room. During interview on June 28, 2023, at 12:43 p.m., surveyor asked ULP-N if she had set up R3 medications and she stated no, she did not. ULP-N stated she was observing the memory care unit because ULP-F went on break five minutes prior to surveyors' arrival. During interview on June 28, 2023, at 12:47 p.m., licensed practical nurse (LPN)-J stated staff were expected to set up and administer medications off the electronic medication record and practice the "6 rights of medication administration." LPN-J also indicated staff are to stay with the resident until medications are swallowed. LPN-J stated, "That's not good," when she was made aware of the situation.	01760		

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01760	Continued From page 101 During interview on June 28, 2023, at 2:30 p.m., ULP-F stated ULP-N was sitting in memory care watching R3. ULP-F indicated R3 wanted to eat first then take her medications. ULP-F said she notified ULP-N to watch R3 take them. ULP-F then stated, "it looked like R3 was going to take them, put it to her mouth like it was water, then put the medication cup back down." "Usually when medications are given, I watch residents take them." R4 R4's Medication Assessment dated May 31, 2023, indicated staff would manage and administer all of R4's medications including inhalant medications. On June 27, 2023, at 8:05 a.m., surveyor observed ULP-B set up R4's nebulizer medication and hand it to R4. ULP-B then left the room and stated to a trainee, "we have to leave her, or she freaks out and she won't take the nebulizer, but if you leave her to do it alone, she does a good job of taking it. She tells us when there is an issue like earlier when she was telling me that it was leaking so I looked and there was a crack in the plastic, so she is very reliable and will take the nebulizer by herself." On June 27, 2023, at 12:58 p.m., registered nurse (RN)-D stated, "she is not approved to administer her own nebs. Her assessment is marked that the ULP should be doing it and there is nothing in the orders that says she is ok to self-administer." TRANSCRIPTION ERROR R5 R5 began receiving assisted living services on November 30, 2022, with diagnoses that included	01760		

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01760	Continued From page 102 chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. R5's initial RN Comprehensive Assessment, dated November 30, 2022, indicated R5 was receiving medication management services such as medication set up by the licensee. R5's physician orders dated April 20, 2023, ordered metformin 500 mg tablet extended release-2 tablets by mouth two times a day with meals for diabetes. R5's physician orders dated April 25, 2023, ordered metformin 850 mg tablet-1 tablet by mouth two times a day with meals for diabetes. The following medication on the MAR was documented by staff on various shifts and various days of the month: -metformin 500 mg-two tablets twice a day for diabetes on 23 scheduled times for June 1 through June 30, 2023-(6) of those documented, "drug refused." Four of those documented, "other/ see nurse notes." Thirty-seven scheduled times were left blank. During interview on June 30, 2023, at 12:29 p.m., RN-D stated they tried to figure out the metformin order and RN-D was told by R5 that 1000 mg upset her stomach, so the physician decreased the dose to 850 mg. RN-D stated the LPN manually entered in the order on the MAR. RN-D stated they asked LPN-J about the order and LPN-J could not explain why the 1000 mg was still on the MAR and not the 850 mg dose. RN-D also stated there was no progress note to explain the discrepancy.	01760		

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01760	Continued From page 103 On June 27, 2023, at 1:00 p.m., RN-D stated, "Medications should be documented after administration, if it is not documented it didn't happen and that should have been reported to the nurses to investigate. So, I will look into why there is no documentation." The licensee's Medication Management Services policy dated April 24, 2023, indicated a nurse would review the resident's medication record during medication setups, monitoring visits, and other appropriate times to verify staff are administering the medications as prescribed and are documenting the admission appropriately with authentication be each staff person by discipline or title. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01820		

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01820	Continued From page 104 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: R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's Medication Administration Record (MAR), dated June 1, 2023, through June 30, 2023, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that Levothyroxine 75 micrograms (mcg) was administered once daily on June 1, 3-9, 12, 13, 15, 17-23, and 26-29. ClonazePam 0.5 milligram (mg) was administered once in the mornings on June 1, 3-9, 12-15, 17-23, and 26-29, and once in the evenings on June 1-17, 20, and 22-29. Cholecalciferol 125 mcg was administered once daily on June 1, 3-9, 12, 13, 15, 17-23, and 26-29. Cetirizine hydrochloride10 mg was administered once daily on June 1, 3-7, 9, 12, 13, 15, 17-23 26, and 27. Baclofen oral tablet 5 mg was administered once daily on June 7, twice daily on June 8, 10, 11, 13, 14, 16,18-22, 24, 25,	01820		

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01820	Continued From page 105 27 and 29, and three times daily on June 9, 12, 15, 17, 23, 26, and 28. Aspercreme Lidocaine external cream 4 percent (%) was administered in the mornings on June 3-9, 12-15, 17-23, and 26-29, and once in the evenings on June 4-17, 20, and 22-29. R3's most recent provider orders for the following 12 medications were signed on February 8, 2022. -Levothyroxine 88 micrograms (mcg) by mouth one time daily; -Depakote sprinkles 125 milligrams (mg) by mouth two times daily; -Fiber-Lax 625 mg by mouth one time daily; -fluticasone propionate suspension 50 mcg -ibuprofen 600 mg every six hours as needed; -lactulose solution 10 grams (gm) per milliliter (ml) by mouth one time daily; -meclizine hydrochloride 25 mg by mouth every eight hours as needed; -calcium carbonate-vitamin D by mouth two times daily; -Paroxetine hydrochloride 50 mg by mouth one time daily; -multivitamin by mouth one time daily; and -vitamin D3 25 mcg by mouth one time daily. The surveyor did not receive signed orders for the following medications prior to survey completion: -Levothyroxine 75 mcg orally one time a day, -ClonazePam 0.5 mg orally two times a day, -Cholecalciferol 125 mcg orally one time a day, -Cetirizine hydrochloride10 mg orally one time a day, -Baclofen oral tablet 5 mg orally three times a day, and -Aspercreme Lidocaine external cream 4% apply to feet topically two times a day. On June 29, 2023, at 10:15 a.m., licensed	01820		

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01820	Continued From page 106 assisted living director (LALD)-C acknowledged the most recent signed annual orders that were dated February 8, 2022, were the orders the licensee had on file. LALD-C stated, "those are the only orders we have for [R3] in her files." On June 29, 2023, at 3:23 p.m., registered nurse (RN)-D who was a contract nurse filling in while the clinical nurse supervisor was on leave, stated, "We have to have a prescription order no matter what the medication is if we are giving it. You can't give a med without an order. I have no idea why there is no orders for those medications." The licensee's Medication Prescriptions, Refills, Supplies-Requests & Delivery policy dated April 24, 2023, indicated the RN would be responsible to obtain signed orders for all medications that would be managed by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R3).	01830		

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01830	Continued From page 107 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: R3 was admitted to the licensee and began receiving services on September 6, 2019. R3's diagnoses included epilepsy, multiple sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts, laundry, and medication administration. R3's most recent provider orders for the following 12 medications were signed on February 8, 2022. -Levothyroxine 88 micrograms (mcg) by mouth one time daily; -Depakote sprinkles 125 milligrams (mg) by mouth two times daily; -Fiber-Lax 625 mg by mouth one time daily; -fluticasone propionate suspension 50 mcg -ibuprofen 600 mg every six hours as needed; -lactulose solution 10 grams (gm) per milliliter (ml) by mouth one time daily; -meclizine hydrochloride 25 mg by mouth every eight hours as needed; -calcium carbonate-vitamin D by mouth two times daily;	01830		

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01830	Continued From page 108 -Paroxetine hydrochloride 50 mg by mouth one time daily; -multivitamin by mouth one time daily; and -vitamin D3 25 mcg by mouth one time daily. On June 29, 2023, at 1:16 p.m., registered nurse (RN)-D stated, "Prescription orders need to be renewed every 12 months or sooner. There is no reason these shouldn't have been renewed, the providers round here in the building." The licensee's Medication Prescriptions, Refills, Supplies-Request & Delivery policy dated April 24, 2023, indicated the nurse would assure that the prescriber renews a medication prescription every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for nine of 11 residents (R10, R11,	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

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01890	Continued From page 109 R12, R13, R14, R15, R16, R17, and R20). 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: On June 27, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the medication cart within the nursing office was used for overstock (extra) medications, and medication set ups. LPN-A stated they did not have a process for checking for expired medications. EXPIRED MEDICATIONS -R10-eight (8) expired medications ranging from October 31, 2018, through June 1, 2023; -R11-five (5) expired medications ranging from September 30, 2022, through June 1, 2023; -R12-two (2) expired medications on May 1, 2023, and June 1, 2023; -R13-five (5) expired medications ranging from January 31, 2023, through June 1, 2023; -R14-two (2) expired medications on October 18, 2022, and February 24, 2023; -R15-two (2) expired medications on March 31, 2023, and May 31, 2023; -R16-one (1) expired medication on April 1, 2023; -R17-one (1) expired medication on February 28, 2023; and -R20-one (1) expired medication on March 31, 2023.	01890		

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01890	Continued From page 110 During interview on June 29, 2023, at 3:03 p.m., registered nurse (RN)-D stated licensee should have been doing medication cart audits every two weeks to check for expired medications. RN-D stated it was not okay to hold onto any expired residents' medication and should be destroyed. RN-D also stated all medications should bear original label and if it is over the counter medication, it should have first initial and full last name of a resident. The licensee's Storage of Medications policy dated July 29, 2021, effective August 1, 2021, indicated 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 quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The licensee's Disposition or Disposal of Medication policy dated July 29, 2021, effective August 1, 2021, indicated the licensee would destroy unused or discontinued medications and document the date it was destroyed, quantity, name of drug, prescription number, signature of person destroying the medications, and signature of witness to the destruction. The destruction record must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 111	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications were destroyed when medications were no longer in use. This had the potentional to affect all residents receiving medication management. 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	01910		

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01910	Continued From page 112 portion or all of the residents). The findings include: On June 27, 2023, at 9:15 a.m., licensed practical nurse (LPN)-A stated the medication cart within the nursing office was used for overstock (extra) medications, and medication set ups. LPN-A stated they did not have a process for checking for expired medications. Surveyor asked if licensee had central house stock medications, which any resident with a provider order can use over-the-counter medications. LPN-A stated licensee did not use central house stock medications. Every resident had their own medications. On June 27, 2023, at 9:25 a.m., surveyor observed bottles of Miralax (used for constipation) where the residents names were blocked out by a black sharpie pen. LPN-A stated, "they were probably used for other residents if someone ran out", and "I hate to toss them." LPN-N showed surveyor where staff document medication destruction when medications either expire or when resident discharges. In addition, the following medications were observed to have the top part of the bubble pack ripped off or pharmacy label missing from the bottle which contained the name of resident, name of medication, dose, and instructions how to take them: -vitamin B12 500 micrograms (mcg)-1/3 of bottle, expires on October, 2025; -pain relief 325 milligrams (mg), 1/4 of bottle, expires May, 2025; -senna 8.6 mg, new sealed bottle, expires November 2025;	01910		

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01910	Continued From page 113 -vitamin D3 2000 units (u), 25 pills expired on March 1, 2023; -furosemide (diuretic) 40 mg, 7 pills, expires on July 1, 2023; -Narcan spray (for overdose) 4 mg nasal spray, 2 sprays, expired September, 2021; -atorvastatin (high cholesterol) 40 mg, 25 pills, expired on June 30, 2022; and -polyethylene glycol 3350, 14 packets, expires December, 2024. During interview on June 29, 2023, at 3:03 p.m., registered nurse (RN)-D who was a contract nurse filling in while the clinical nurse supervisor was on leave, stated licensee should have been doing medication cart audits every two weeks to check for expired medications. RN-D stated it was not okay to hold onto any expired residents' medication and the medications should be destroyed. RN-D also stated all medications should bear original label and if it is over-the-counter medication, it should have first initial and full last name of a resident. The licensee's Storage of Medications policy dated July 29, 2021, effective August 1, 2021, indicated 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 quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. The licensee's Disposition or Disposal of Medication policy dated July 29, 2021, effective August 1, 2021, indicated the licensee would destroy unused or discontinued medications and	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 114 document the date it was destroyed, quantity, name of drug, prescription number, signature of person destroying the medications, and signature of witness to the destruction. The destruction record must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	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	01940		

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01940	Continued From page 115 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 a treatment management plan to include all required content for one of one resident (R5) with blood glucose monitoring and continuous positive airway pressure (CPAP) machine. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. Surveyor observed a CPAP machine on the floor next to R5's bed. R5 stated the licensee was charging her $16 dollars	01940		

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01940	Continued From page 116 per day to record her blood glucose checks she performs three times a day. R5 also stated, "a lot of times, they don't ask me the results." R5's admission orders signed November 25, 2022, ordered to check blood glucose three times a day. On the same order, it indicated CPAP equipment was being ordered. R5's most recent Registered Nurse (RN) Comprehensive Assessment dated March 13, 2023, did not assess whether R5 needed assistance with blood glucose checks or CPAP machine. Under "Review," it indicated the RN reviewed the individual treatment/therapy plan. R5's record lacked a service plan. R5's Task List Report printed June 30, 2023, indicated R5 received weekly medication set up, daily homemaking, daily linen, and the following on an as needed basis: pull cord, shower assistance, escorts, laboratory coordination, and additional services by ULP. R5's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated to check blood glucose three times a day for monitoring at 8:00 a.m., 11:00 p.m., and 4:00 p.m. which was initiated November 30, 2022. The MAR also had a duplicate to check blood glucose three times a day instructing staff to ask R5 what her blood glucose result was and to record at the same times. The duplicate was initiated on December 1, 2022. For the month of June 2023, out of 90 records, 49 were documented. R5's record lacked a Medication Treatment therapy Management Plan to include the following	01940		

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01940	Continued From page 117 content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -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. On June 29, 2023, at 2:15 p.m., ULP-N stated she initially observed R5 check her own blood glucose, but had not observed it for a while. R5 will just tell her what the result was. On June 30, 2023, at 12:29 p.m., RN-D confirmed there were no instructions on when to notify the nurse if a blood glucose was low or high. RN-D stated the treatment should have been included in the RN assessment. The licensee's Initial and On-going Nursing Assessment of Resident's Under the Comprehensive Licensed Agency policy dated July 29, 2021, effective August 1, 2021, indicated the RN comprehensive assessment would include a list of treatments including the type, frequency and level of assistance needed. No further information was provided.	01940		

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01940	Continued From page 118 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident receiving blood glucose monitoring (R5). 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	01950		

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01950	Continued From page 119 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on November 30, 2022, with diagnoses that included chronic obstructive pulmonary disease (COPD) (breathing difficulty), depression, anxiety, cognitive decline, and memory issues. During interview with R5 in her apartment on June 28, 2023, at 2:55 p.m., R5 stated she managed her own medications including insulin and blood glucose checks. R5 stated the licensee was charging her $16 dollars per day to record her blood glucose checks she performs three times a day. R5 also stated, "a lot of times, they don't ask me the results." R5's admission orders signed November 25, 2022, ordered to check blood glucose three times a day. R5's record lacked a service plan. R5's medication administration record (MAR) dated June 1, 2023, through June 30, 2023, indicated to check blood glucose three times a day for monitoring at 8:00 a.m., 11:00 p.m., and 4:00 p.m. which was initiated November 30, 2022. The MAR had a duplicate to check blood glucose three times a day instructing staff to ask R5 what her blood glucose result was and to record at the same times. The duplicate was initiated on December 1, 2022. For the month of June 2023, out of 90 records, 49 were	01950		

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01950	Continued From page 120 documented. During this time frame blood glucose results ranged from 128 to 281 milligrams (mg)/deciliter (dL). R1's record lacked specific written instructions for blood glucose monitoring to include parameters for evaluation of results. During interview on June 30, 2023, at 8:10 a.m., ULP-G was working on the unit R5 lived in. ULP-G stated she asks R5 for the blood glucose results, but has never seen R5 check her blood glucose nor the book she keeps track of her results in. Surveyor asked ULP-G if there were instruction on when to notify the nurse and ULP-G stated, "I don't think so, but I have been trained on it a long time ago for another resident." On June 30, 2023, at 12:29 p.m., RN-D confirmed there were no instructions on when to notify the nurse if a blood glucose was low or high. The licensee's Treatment and Therapy Management policy dated April 24, 2023, indicated the licensee would provide written instructions of when to notify a licensed nurse when problems arose with treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

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02040	Continued From page 121 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On June 29, 2023, approximately from 10:45 a.m. to 1:05 p.m., survey staff toured the facility with the director of maintenance (DOM)-I and maintenance staff (M)-K. The licensed assisted living director (LALD)-C joined the tour at 11:45	02040		

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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
02040	Continued From page 122 a.m. On June 29, 2023, at approximately 2:00 p.m., a document review and interview with the LALD-C, the DOM-I, and the M-K relating to the memory care site-specific safety risk/vulnerability assessment and mitigation plan indicated the licensee lack the required plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. Survey staff requested documentation for the review, but one was not provided or available for review, and the finding was confirmed during the interview with the LALD-C and DOM-I that the licensee lacked the required plan. Survey staff discussed the finding and explained that all potential safety risks and/or vulnerabilities specific to memory care residents on and around the property must be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. On June 29, 2023, at approximately 2:30 p.m., during the exit interview, the M-K, the LALD-C, and DOM-I acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who	02070		

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	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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02070	Continued From page 123 is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an awake person was physically present in a secured care unit, 24 hours a day, seven days a week who was responsible for responding to requests of residents for assistance in a secured area. This had the potential to affect all residents in the secured dementia care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R7 was admitted on January 31, 2022, and resided in the unsecured area of the facility. R7's Resident Incident Report dated June 26, 2023, at 2:50 a.m., read, "resident observed on floor sitting by her chair. She stated she slid down from her recliner." The licensee's daily schedule provided by LALD-C dated June 22 - July 5, 2023, indicated two (2) staff members were working on the NOC (commonly used term for the overnight) shift. One	02070		

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02070	Continued From page 124 staff was assigned to the secured unit, and one assigned to the unsecured unit. On June 27, 2023, at 6:10 a.m., unlicensed personnel (ULP)-H stated they sometimes leave the secured memory care unit on the overnights to assist with a fall in the unsecured unit. ULP-H stated, "We [staff] call each other on the walkies and if she [other staff] needs my help I will leave here [secured memory care unit] and go help her, I am always going up to [R7's] to help get her up off the floor. I don't go right away; I go and check my residents that are fall risks and then once I ensure they are safe then I go. Sometimes I can't go right away because sometimes I need to toilet someone or get them settled down before they are safe to leave. This happened just night before last [June 26, 2023], I remember because my shoulder still hurts from it." On June 27, 2023, at 8:42 a.m., LALD-C stated, "what we do for staffing is one person and the float who is the person assigned to the third group [on the morning and afternoon shift] is the back up for memory care. Right now, with there being just a few people [residents] the needs are not that high, but someone is always supposed to be in there [the secured unit]. For over nights memory care staff can't leave memory care. But I did look at our policy and our staffing plan and they don't actually say that the memory care staff can't leave the unit, so I will need to do some re-education with them." The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated, August 1, 2021, read, "A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two."	02070		

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02070	Continued From page 125 No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		
02110 SS=C	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: (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	02110		

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02110	Continued From page 126 (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 ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for four of four residents (R1, R3, R4, and R5). 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 the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee on August 2, 2021. R3 was admitted to the licensee on September 6, 2019. R4 was admitted to the licensee on March 10, 2012. R5 was admitted to the licensee on November 30, 2022. R1, R3, R4 and R5's records lacked evidence the	02110		

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02110	Continued From page 127 licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. On June 29, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated, "I was unable to locate the dementia policies, but I will keep looking." No policies were provided to the surveyor by the close of survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not	02170		

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02170	Continued From page 128 limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R3 and R4) who resided in the secured memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility had an assisted living with dementia care license, effective August 1, 2021. R3's diagnoses included epilepsy, multiple	02170		

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02170	Continued From page 129 sclerosis, and mild cognitive impairment of uncertain or unknown etiology. R4's diagnoses included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and major depressive disorder. R3 and R4's records lacked documentation of evaluation of the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On June 28, 2023, at 11:22 a.m., activities coordinator (AC)-L stated, "I'm unaware of the requirements, I know we do not do any activities assessments for any of the residents." The licensee's undated Recreation/Activities policy read, "Recreational opportunities should be offered based on the interests of the residents. The assisted living statute requires that 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 is offered. There are additional requirements for settings licensed as ALDC. Programs must be culturally sensitive." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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02310	Continued From page 130	02310		
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 provide care and services according to acceptable health care, medical or nursing standards for two of five residents (R3, R8) with consumer bed rails and assistive devices. 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: R3 R3 had diagnoses to include multiple sclerosis, mild cognitive impairment of uncertain or unknown etiology, other amnesia, and unspecified mood disorder. R3's unsigned Service Agreement dated February 17, 2023, indicated R3 received morning/evening (AM/PM) cares, bathing, homemaking, escorts,	02310	On June 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three widespread violation.	

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02310	Continued From page 131 laundry, and medication administration. On June 27, 2023, at 6:40 a.m., the surveyor observed R3's bed had one Halo Safety Ring bed rail (consumer bed rail) at the top of the bed on the side not against the wall. The bed rail was firmly attached to the bed. The surveyor also observed a chair grab bar assistive device that was secured from the ceiling to the floor on the right side of the chair and an unsecured grab bar assistive device on the left of the chair. R3 stated they used the bed rail, and the chair grab bars for positioning in bed and chair and for getting in and out of bed or chair. Unlicensed personnel (ULP)-B stated R3 utilized all the assistive devices and stated, "it helps her to try to keep some independence because she has been declining." R3's record included a Bedrail Assessment for Those Clients Who Have A Bedrail dated January 3, 2022. R3's record lacked: -Documentation the bed rail and chair grab bars were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rail and chair grab bars for areas of entrapment, stability, and correct installation; -Assistive device assessment for the floor to ceiling grab bar; and -Assistive device assessment for the unsecured grab bar. R8 R8 had diagnoses of depression, osteoarthritis, unspecified dementia, and chronic pain. R8's unsigned Service Agreement dated February	02310		

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02310	Continued From page 132 17, 2023, indicated R8 received AM/PM cares, bathing, homemaking, escorts, laundry, and medication administration. On June 27, 2023, at 10:20 a.m., the surveyor observed R8 had a black oblong shaped consumer bed rail affixed to the top of the bed on the side not against the wall. The bed rail was not firmly attached to the bed. R8's record included a Bedrail Assessment for Those Clients Who Have A Bedrail, dated March 28, 2022, indicated R8 had no bed rails and sleeps in recliner. R8's comprehensive assessment dated May 9, 2023, lacked a bed rail assessment. R8's record lacked: -Documentation the bed rail was installed, used, and maintained per manufacturer's guidelines; and -Documentation of bed rail for areas of entrapment, stability, and correct installation. On June 26, 2023, at 2:17 p.m., licensed assisted living director (LALD)-C stated, "I asked the nurses if there were any bedrails and there are none, unless one came in over the weekend and we have not been told about it yet." On June 27, 2023, at 10:37 a.m., (LALD)-C stated, "I did not know that [R8] had a bedrail and so I don't really know how many more we will find, like I told you yesterday, I asked my staff if we had any bedrails, and everyone told me no, so I didn't realize we had any, I thought we might have one for one guy but I looked and he doesn't have any."	02310		

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02310	Continued From page 133 On June 27, 2023, at 10:37 a.m., the surveyor asked R8 if they used the bedrail to help with bed mobility and R8 stated, "oh yes." On June 27, 2023, at 10:37 a.m., the surveyor asked R8 if they slept in the recliner and R8 stated, "oh yeah, I suppose." The Food and Drug Administration (FDA) guidance A Guide to Bed Safety dated 2000, and revised April 2010, indicated 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 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." The MDH website indicated for consumer bed rails, the licensee must include	02310		

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02310	Continued From page 134 in their documentation: - 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". The licensee's Assessing the Safety Of Side Rails policy dated January 2014, indicated staff would alert the Registered Nurse (RN) if a resident had any type of bed rail or similar equipment and the RN would evaluate whether the bed rail appeared to be safe for the resident. The RN would educate the resident, their representative and/or family members about the risks related to bed rails, and if the resident's bed rails appeared not to meet FDA standards, the RN would recommend to the resident, the resident representative, or the resident's family involved. TIME PERIOD FOR CORRECTION: Immediate	02310		
02480 SS=D	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact	02480		

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02480	Continued From page 135 information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the results of reviewed grievances for two of three known residents (R18, R19). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A Compliments/Concerns document dated December 14, 2023 [sic] indicated R18 was very afraid of R1 due to physical actions that occurred on July 15th of the same year and wanted to press charges for R1's actions. The rest of the document was left blank with no documented actions taken or who addressed it. A Compliments/Concerns document dated January 14, 2023, indicated R19 made a complaint about R1 urinating outside on chairs, spitting on the porch and that he hit R19 on the face and nicked R19's nose. The rest of the document did not have documented actions taken and by whom. A Compliments/Concerns document dated April 4, 2023, indicated R1 verbally altercated R18 at	02480		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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
02480	Continued From page 136 the dining room table on April 2nd and indicated the licensee hasn't "gotten rid of R1 yet." The document had registered nurse (RN)-M's signature and date, but lacked documented actions taken. A Compliments/Concerns document undated by "a concerned resident," indicated that resident was afraid of R1 because he broke the windows, raised his hand to the resident and swears all the time. On June 28, 2023, at 10:30 a.m., licensed assisted living director (LALD)-C stated the complaints were followed up with the residents in person but wasn't sure if there was documentation available. LALD-C was going to search for those documents. LALD-C did not provide any additional documents. On June 28, 2023, at 11:19 a.m., LALD-C stated the incidents mentioned before occurred before R1 was hospitalized in November of 2022, and when R1 returned to the facility, R18 and R19 submitted the complaints. LALD-C stated the residents were trying to get R1 kicked out before R1 was hospitalized. The licensee's Complaint Policy and Procedure effective date August 1, 2021, indicated the LALD would review the complaint and determine the most appropriate staff person to investigate and follow-up and assign the complaint to that staff person and that staff person would complete the complaint investigation and follow-up and document appropriately on the complaint form. Additionally, the policy indicated complaints and resolution would be kept in the resident's record for the length of their stay at the facility.	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21871	A. BUILDING: _____ B. WING _____	06/30/2023

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CREST VIEW ON 42ND	900 42ND AVENUE NE COLUMBIA HEIGHTS, MN 55421

(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
02480	Continued From page 137 TIME PERIOD FOR CORRECTION: Seven (7) days	02480		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/28/23*
Time: 13:13:31
Report: 1036231161

Food and Beverage Establishment Inspection Report

Location:

Crest View On 42nd
900 42nd Avenue Ne
Columbia Heights, MN55421
Anoka County, 02

Establishment Info:

ID #: 0039084
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637821611
ID #:

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

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THE HANDWASHING SINK BY THE DISH MACHINE IS CURRENTLY OUT OF ORDER. REPAIR AND MAINTAIN.

Comply By: 07/03/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 171.7 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: DINING ROOM SANI BUCKET
Violation Issued: No

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: KITCHEN SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: ARCTIC AIR SINGLE DOOR COOLER
Violation Issued: No

Type: Full
Date: *06/28/23*
Time: 13:13:31
Report: 1036231161
Crest View On 42nd

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: BEVERAGE AIR SINGLE DOOR COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -7 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Process/Item: Cold Hold/CREAM
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Holding/BEANS
Temperature: 169 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: Hot Holding/PATTY MELT
Temperature: 165 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

Announced inspection. Tesa Brown was the lead RN with HRD completing the site survey. Inspection conducted with CFPM Chris Jones.

Discussed the following with CFPM:
Employee illness policy and logging requirements
Glove-use
Handwashing procedure
No bare hand contact with ready to eat food
Thermometer use/calibration
Proper food storage
Sanitizing procedures for food contact surfaces
Fully cooking food for high risk populations
Violations on this report

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *06/28/23*
Time: 13:13:31
Report: 1036231161
Crest View On 42nd

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036231161 of 06/28/23.

Certified Food Protection Manager: Christopher M. Jones

Certification Number: FM88711 Expires: 04/19/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Christopher Jones
Kitchen Manager

Signed: _____
Jeff Johanson