Electronically Delivered

October 2, 2023

Licensee
Pioneercare - Memory Cottages
1317 South Mabelle Avenue
Fergus Falls, MN 56537

RE: Project Number(s) SL21568015

Dear Licensee:

On September 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 12, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	R 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL21568015-1 On September 21, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 12, 2023. At the time of the survey, there were 33 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{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	{0 470}		

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{0 470}	Continued From page 1 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: No further action required.	{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: No further action required.	{0 480}		

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{0 510}	Continued From page 2	{0 510}		
{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: No further action required.	{0 510}		
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: No further action required.	{0 700}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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

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{0 950}	Continued From page 4	{0 950}		
{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: No further action required.	{0 950}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 5 (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: No further action required.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) 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; (2) the identification of staff or categories of staff	{01650}		

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{01650}	Continued From page 6 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	{01750}		

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{01750}	Continued From page 7 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: No further action required.	{01750}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	{01790}		

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{01790}	Continued From page 8 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	{01790}		

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{01790}	Continued From page 9 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action required.	{01790}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}		

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{01890}	Continued From page 10 This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}		
{01950} SS=E	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	{01950}		

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{01950}	Continued From page 11 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: No further action required.	{01950}		
{01960} SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action required.	{01960}		

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{01970}	Continued From page 12	{01970}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action required.	{01970}		
{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}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services	{02310}		

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{02310}	Continued From page 13 (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: No further action required.	{02310}		
{02410} SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced	{02410}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	R 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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
{02410}	Continued From page 14 by: No further action required.	{02410}		

Electronically Delivered

July 26, 2023

Licensee
Pioneercare - Memory Cottages
1317 South Mabelle Avenue
Fergus Falls, MN 56537

RE: Project Number(s) SL21568015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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 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 state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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: SL21568015 On July 10, 2023, through July 12, 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 31 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. On July 11, 2023, at 4:35 p.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the daily staffing schedule was posted as required. 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	0 470		

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0 470	Continued From page 2 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 held an assisted living with dementia care license. The facility was licensed for a capacity of 52 and had a current census of 31 residents. During the entrance conference on July 10, 2023, at 11:09 a.m., registered nurse (RN)-K stated the licensee had a staffing plan developed by several different staff members and had ongoing review. The surveyor requested the staffing plan, which was later provided. On July 10, 2023, at 3:46 p.m., the surveyor did not observe the daily staffing schedule posted in the facility. CNS-B stated the staffing schedule was normally posted on the door in the dining room, however someone must have took it down. On July 11, 2023, at 2:16 p.m., the surveyor reviewed the staffing plan with CNS-B. CNS-B stated the staffing plan had not been reviewed every six months nor signed by CNS-B. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated August 1, 2021, indicated the daily work schedule will be posted at the beginning of each shift. In addition, the staffing plan will be developed by the CNS and revised at minimum of two times per year. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD OF CORRECTION: Twenty-One (21) 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: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 510		

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0 510	Continued From page 4 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of three unlicensed personnel (ULP)-H) during medication administration and four of four ULPs (ULP-P, ULP-G, ULP-H, ULP-N) by disinfecting shared equipment in between resident use. In addition, the licensee failed to ensure infection control standards were followed for one of four ULPs (ULP-J) with hand hygiene Further, the licensee failed to ensure infection control standards were followed for one of four ULPs (ULP-O) with dress code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 510		

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0 510	Continued From page 5 MEDICATION ADMINISTRATION During the entrance conference on July 10, 2023, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. On July 11, 2023, at 7:49 a.m., the surveyor observed ULP-H provide scheduled morning medication administration to an unidentified resident. ULP-H took out the unidentified resident's bubble packs (medication packs set up daily by pharmacy) and placed the medications into a paper cup. ULP-H then proceeded to crush the medications in a plastic sleeve. During the process of emptying the plastic sleeve of crushed medications back into the paper cup, some of the crushed medication fell onto the counter. ULP-H stated, "oops you didn't see that" and then scraped the crushed medications off the counter into the plastic cup. ULP-H then proceeded to mix the crushed medications into yogurt and brought the medication to the unidentified resident to administer. On July 11, 2023, at 11:07 a.m., CNS-B stated any medication spilled onto a dirty surface should be destroyed and not be administered to a resident. REUSABLE EQUIPMENT ULP-P On July 10, 2023, at 3:58 p.m., the surveyor observed ULP-P place a wrist blood pressure machine onto an unidentified resident's wrist and stated 141/85. ULP-P placed a thermometer on the resident's forehead and stated 98.7. ULP-P placed a pulse oximeter (a small device that attaches to a finger on the resident's hand. The monitor displays a reading of how saturated the	0 510		

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0 510	Continued From page 6 blood is with oxygen) on a resident's finger and wrote down 93% on a piece of paper. ULP-P went to the kitchen and got a cup of cider for another resident and washed her hands. ULP-P approached R12 and placed the thermometer on R12's forehead and stated 97.8. ULP-P placed the pulse oximeter onto a finger and applied the wrist blood pressure cuff onto R12's right wrist. The surveyor did not observe ULP-P disinfect the blood pressure cuff, pulse oximeter, or thermometer between residents. On July 10, 2023, at 4:20 p.m., ULP-P stated she did not clean the equipment between residents. ULP-P said the equipment should have been cleaned but she was "trying to get everyone done." ULP-G On July 11, 2023, at 7:38 a.m., the surveyor observed ULP-G complete R4's vital signs. ULP-G used a shared resident blood pressure cuff, a shared resident thermometer for the forehead, and a shared resident pulse oximeter. ULP-G completed R4's vital signs and returned the shared equipment back to the counter in the care givers office. The surveyor did not observe ULP-G clean the shared equipment before or after use. ULP-H On July 11, 2023, at 9:10 a.m., the surveyor observed ULP-H complete an unidentified resident's vital signs. ULP-H used a shared resident blood pressure cuff, a shared resident thermometer for the forehead, and a shared resident pulse oximeter. ULP-H completed the unidentified resident's vital signs and returned the shared equipment back to the counter in the care givers office. The surveyor did not observe	0 510		

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0 510	Continued From page 7 ULP-H clean the shared equipment before or after use. ULP-N On July 11, 2023, at 10:13 a.m., the surveyor observed ULP-N complete R5's vital signs. ULP-N used a shared resident blood pressure cuff, a shared resident thermometer for the forehead, and a shared resident pulse oximeter. ULP-N completed R5's vital signs and returned the shared equipment back to the counter in the care givers office. The surveyor did not observe ULP-N clean the shared equipment before or after use. On July 11, 2023, at 10:18 a.m., ULP-H and ULP-N stated shared resident equipment should be cleaned after use with each resident. On July 11, 2023, at 11:06 a.m., CNS-B stated shared equipment should be cleaned before and after each use. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated August 1, 2021, indicated after reusable equipment use, the equipment must be cleaned and returned to the place that is stored. HAND HYGIENE ULP-J On July 12, 2023, at 8:26 a.m., the surveyor observed ULP-J apply gloves and administer R2's eye drops. With same gloved hands ULP-J cleaned R2's middle finger of his right hand and allowed time for the finger to dry. ULP-J inserted a test strip into the blood glucose (BG) meter (device that will test blood sample to determine blood glucose level) and used a lancet (small needle used to poke the skin [usually on a finger]	0 510		

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0 510	Continued From page 8 to get a small drop of blood). The blood sample was put onto the BG testing strip. The BG meter indicated R2's BG was 132. ULP-J returned the BG meter to its storage bag and removed the gloves she had been wearing. ULP-J documented medication administration and BG monitoring. ULP-J commented she was going to go assist an unidentified resident. The surveyor did not observe ULP-J perform hand hygiene after glove removal. Directly following the above observation ULP-J stated she did not wash her hands. ULP-J said hands should be washed any time gloves are taken off, "you wash hands". On July 12, 2023, at 11:49 a.m., CNS-B stated her expectation was for staff to wash their hands when gloves are removed. The licensee's Administration of Medication, Treatment, and Therapy by ULP policy dated August 1, 2021, indicated infection control precautions must be followed when administering medications, treatment and therapy. DRESS CODE ULP-O On July 11, 2023, at 8:25 a.m., the surveyor observed ULP-O prepare and administer R10's morning medication. The surveyor observed ULP-N wearing open toed shoes. On July 11, 2023, at 10:28 a.m., registered nurse (RN)-K stated she believed their policy stated open toed shoes were not to be worn adding it was in the dress code. RN-K said open toed shoes would be a safety and an infection control issue.	0 510		

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0 510	Continued From page 9 The Employee Handbook, undated, noted on page 33, Dress Codes Specific to Departments: In addition to the dress code as outlined for all department, the following specific guidelines also apply, Nursing: -Shoes must be clean and good-fitting. No open toed shoes. Athletic style shoes are encouraged. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was protected and kept private. This had the potential to affect all 31 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	0 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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0 700	Continued From page 10 or has the potential to affect a large portion or all of the residents). The findings include: The assisted living with dementia care facility had two separate buildings as part of their license (Heartland building and Heritage building). HEARTLAND BUILDING On July 10, 2023, the surveyor toured the Heartland building and observed a room with two open doors. Unlicensed personnel (ULP)-F stated the doors to this room are kept open for the "most part". ULP-F added the room was the caregiver's office. On July 10, 2023, at 11:44 a.m., the surveyor observed an open computer screen displaying resident health and medical information in the caregiver's office. Directly after the above observation licensed assisted living director (LALD)-A stated the computer screens in the office should be shut down. LALD-A added the Heartland and Heritage buildings mirrored each other. On July 11, 2023, from 8:02 a.m. through 9:02 a.m., the surveyor observed an open computer screen sitting on the desk in the caregiver's office. The computer screen displayed resident names and medication information. Both staff doors were open and adjacent to the office were dining room tables where residents were seated within site of the computer screens. On July 11, 2023, at 9:08 a.m., ULP-H stated the computer screens should be off and was nervous with the surveyor present.	0 700		

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0 700	Continued From page 11 On July 11, 2023, at 11:04 a.m., clinical nurse supervisor (CNS)-B stated the expectation of staff was to shut computers or lock the computer screens when not in use. HERITAGE BUILDING On July 11, 2023, at 8:20 a.m., the surveyor observed an open computer screen displaying resident health and medical information in the caregiver's office. The surveyor observed ULP-I taking vital signs in the common's area in the Heritage building. On July 11, 2023, at 8:50 a.m., ULP-I stated, he "probably" forgot to shut the computer screen and added it should be closed as he closed the screen. On July 11, 2023, at 10:24 a.m., registered nurse (RN)-K stated the computer screens should not be left open. RN-K added she taught him how to lock the screen. RESIDENT RECORDS On July 10, 2023, at approximately 10:45 a.m., the surveyor observed two unattended resident's charts sitting on a table in a room off the commons area. The glass French doors to this room where in the opened position. On July 10, 2023, at 11:43 am., LALD-A stated resident charts had been set out for a "providing coming". LALD-A said they (resident charts) should be put away, as she removed them from the "sunroom". The licensee's Security of Resident Records policy dated August 1, 2021, indicated all resident records must be kept confidential and accessible	0 700		

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0 700	Continued From page 12 only to authorized agency personnel. In addition, devices such as laptops will be kept secured and encrypted. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 700		
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	0 810		

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0 810	Continued From page 13 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 10, 2023, at approximately 2:15 p.m. with Maintenance Director (MD)-D, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was vague and did not	0 810		

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0 810	Continued From page 14 provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, MD-D, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 950	Continued From page 15	0 950		
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: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of three residents (R2, R3, R11).	0 950		

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0 950	Continued From page 16 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: R2 R2's service plan, dated July 30, 2021, indicated services included assistance with bathing, grooming, dressing, toileting, medication administration, housekeeping, and laundry. R2's record did not contain evidence of a notice for R2 to identify a designated representative or documentation that R2 declined to name a designated representative. On July 12, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated page 19 of R2's contract was not found, adding R2's record did not have a filled out designated representative form for R2 to identify or decline a designated representative. R3 R3's assisted living contract was signed August 3, 2022. R3's service plan, dated April 24, 2023, indicated services included assistance with bathing, grooming, dressing, toileting, medication administration, housekeeping, and laundry. R3's record did not contain evidence of a notice	0 950		

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0 950	Continued From page 17 for R3 to identify a designated representative or documentation that R3 declined to name a designated representative. On July 12, 2023, at 8:43 a.m., CNS-B stated R3's record did not have a filled out designated representative form for R3 to identify or decline a designated representative and was left blank on page 19 of the contract. R11 R11's assisted living contract was signed November 8, 2022. R11's service plan, dated November 8, 2023, indicated services included assistance with bathing, grooming, dressing, toileting, medication administration, housekeeping, and laundry. R11's record did not contain evidence of a notice for R11 to identify a designated representative or documentation that R11 declined to name a designated representative. On July 12, 2023, at 8:06 a.m., registered nurse (RN)-K stated page 19 had not been completed in R11's record and R11's record did not have a filled out designated representative form for R11 to identify or decline a designated representative. R11's record contained "Right to Designate A Representative For Certain Purposes" form, undated, filed behind R11's contract noted: -you have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive cetin 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	0 950		

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0 950	Continued From page 18 guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable -if you choose to name a Designated Representative, please fill in the information for your Designated Representative on the final page of your Assisted Living Contract. You Designated Representative may be the same individual who has executed your Assisted Living Contract as your Responsible Person. Your Designated Representative may also be an individual serving as either your attorney-in-fact under Power of Attorney or your health care agent -you also have the right to decline to name a Designated Representative. If you do not wish to name a Designated Representative, please initial the applicable box on the final page of your Assisted Living Contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=G	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	01290		

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01290	Continued From page 19 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 current employee records contained all the required content to include a background study clearance letter for one of one employee (maintenance director (MD)-D). This had the potential to affect all residents living within the facility. 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 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: This resulted in an immediate correction order on July 11, 2023, at approximately 3:15 p.m. MD-D was hired on January 2, 1996, and had begun working under the assisted living with dementia care license effective August 1, 2021, to provide maintenance upkeep to the buildings. On July 10, 2023, throughout the afternoon the surveyor observed MD-D in and out of the assisted living with dementia care providing maintenance. MD-D's record lacked documentation of a cleared	01290		

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01290	Continued From page 20 background study. On July 11, 2023, at 2:44 p.m., human resource director (HRD)-L stated she was unable to find confirmation of a cleared background study on Net Study 2.0 for MD-D. The licensee's Background Checks policy dated August 1, 2021, indicated all employees must pass a background study with direct resident contact. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on July 11, 2023, at 4:35 p.m., however, non-compliance remains at a scope and level of three, isolated (G).	01290		
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	01620		

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01620	Continued From page 21 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for three of three residents (R2, R3, R11). In addition, the licensee failed to ensure resident reassessment and monitoring was conducted no more than 14 calendars days after initiation of services for four of five residents (R3, R9, R11, R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: UNIFORM ASSESSMENT TOOL R2 R2's diagnoses included dementia, agitation due to dementia, major depressive disorder, anxiety, and insomnia.	01620		

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01620	Continued From page 22 R2's facility RN Baseline Forms were completed March 27, 2023, and June 22, 2023, respectively. On July 11, 2023, at 10:14 a.m., the surveyor observed unlicensed personnel (ULP)-J complete scheduled medication administration to R2. R3 R3's diagnoses included dementia, chronic kidney disease (kidneys are damaged and can't filter blood effectively), and hypertension (high blood pressure). R3's facility RN Baseline Forms were completed January 26, 2023, and April 24, 2023, respectively. On July 11, 2023, at 8:56 a.m., the surveyor observed ULP-N put on compression stockings (TEDS) for R3. R11 R11's diagnoses included dementia, mood disturbance, anxiety, migraine headaches, and insomnia. R11's facility RN Baseline Forms were completed November 8, 2022, and February 14, 2023, respectively. On July 11, 2023, at 7:58 a.m., the surveyor observed ULP-I complete scheduled medication administration to R11. R2, R3, R11's facility RN Baseline forms lacked the resident's personal lifestyle preferences including: spiritual and cultural preferences. On July 12, 2023, at 8:48 a.m., clinical nurse supervisor (CNS)-B stated the RN Baseline	01620		

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01620	Continued From page 23 Assessment form (90-day comprehensive assessment) was used for all residents and were missing cultural and spiritual preferences of each resident. 14 DAY ASSESSMENT R3 R3 was admitted to the facility on August 3, 2022. R3's facility RN Comprehensive Assessment was dated August 3, 2022, and initialed on November 1, 2022. R3's record lacked a 14-day assessment after R3's initial admission to the facility. On July 12, 2023, at 8:49 a.m., CNS-B stated R3's record was missing a 14-day assessment. R9 R9 was admitted to the facility on December 6, 2022. R9's facility RN Comprehensive Assessments were dated December 20, 2022, and March 17, 2023, respectively. R9's record lacked a 14-day assessment after R9's initial admission to the facility. On July 12, 2023, at 9:03 a.m., RN-K stated R9 was missing a 14-day assessment. R11 R11 was admitted to the facility on November 8, 2022. R11's facility RN Comprehensive Assessments were dated November 8, 2022, and February 14, 2023, respectively.	01620		

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01620	Continued From page 24 R11's record lacked a 14-day assessment after R11's initial admission to the facility. On July 12, 2023, at 8:53 a.m., RN-K stated R11 was missing a 14-day assessment, adding "it should have been done." R13 R13 was admitted to the facility on February 23, 2022. R13's facility RN Comprehensive Assessments were dated February 24, 2023, and May 25, 2023. respectively. R13's record lacked a 14-day assessment after R13's initial admission to the facility. On July 12, 2023, at 9:11 a.m., RN-K stated R13 was missing a 14-day assessment. RN-K spoke with CNS-B regarding 14-day assessments. CNS-B stated the assessment in R9's record, authenticated on December 20, 2022, was R9's admission assessment. CNS-B stated, "about that time" (when those assessments were due) she was reviewing policies, adding in the past 14-day assessments had not been completed. CNS-B said R9, R11 and R13 did not have 14-day assessments completed as required. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated the resident comprehensive assessment would include spiritual and cultural preferences. In addition, a 14-day assessment would be completed up to 14 days after start of services. No further information was provided.	01620		

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01620	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) 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; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01650		

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01650	Continued From page 26 review, the licensee failed to ensure service plans included the required content for three of three residents (R2, R3, 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: R2 R2's diagnoses included diabetes, dementia, agitation due to dementia, major depressive disorder, and anxiety. R2's Service Plan, dated July 30, 2021, indicated services included assistance with bathing, grooming, dressing, toileting, medication administration, housekeeping, and laundry. R2's service plan lacked the schedule and methods of monitoring staff providing services. On July 12, 2023, at 8:26 a.m., the surveyor observed unlicensed personnel (ULP)-J check R2's blood sugar level. R3 R3's diagnoses included dementia, chronic kidney disease (kidneys are damaged and can't filter blood effectively), and hypertension (high blood pressure). R3's Service Plan dated April 24, 2023, indicated R3 received services including medication	01650		

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01650	Continued From page 27 administration, dressing, toileting, bathing, and laundry. R3's service plan lacked the schedule and methods of monitoring staff providing services. On July 11, 2023, at 7:07 a.m., the surveyor observed ULP-N complete scheduled medication administration to R3. R11 R11's diagnoses included dementia, mood disturbance, anxiety, migraine, and insomnia. R11's Service Plan, dated November 8, 2023, indicated services included assistance with bathing, grooming, dressing, toileting, medication administration, housekeeping, and laundry. On July 11, 2023, at 7:58 a.m., the surveyor observed ULP-I complete scheduled medication administration to R11. R2, R3 and R11's service plans lacked the schedule and methods of monitoring staff providing services. On July 12, 2023, at 8:44 a.m., clinical nurse supervisor (CNS)-B stated all resident service plans were the same and lacked the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 28 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. 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) prepared in writing specific instructions for each resident and documented those instructions for two of four residents (R2, R14). 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 R2's diagnoses included diabetes, dementia, agitation due to dementia, major depressive disorder, and anxiety.	01750		

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01750	Continued From page 29 R2's service plan, dated July 30, 2021, indicated staff would provide medication and treatment administration. R2's prescriber's orders dated July 7, 2023, included: -insulin glargine (Lantus SoloStar) subcutaneous injection solution (pen) inject 18 units subcutaneously one (1) time per day. R2's electronic medication record (EMAR) dated July 1, 2023, through July 10, 2023, noted: -Lantus SoloStar (long-acting) Solution Pen-Injector (insulin pen/ a multiple dose pen shaped injector device used for insulin administration)100 units/milliliter (mL). Inject 18 units subcutaneously one time a day for diabetes, reduce blood sugar. On July 11, 2023, at 10:14 a.m., the surveyor observed unlicensed personnel (ULP)-J clean the tip of the insulin pen with an alcohol wipe, apply needle, and prime the pen (removed air bubbles from the needle, to ensure the needle was open and working). ULP-J dialed the pen to 18 units. ULP-J went to R2's side and got on a knee and stated, find upper belly, grab, push and count to five (5). On July 12, 2023, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-B stated R2's record did not contain specific instructions for insulin administration and specific instructions for insulin would not be in any resident's EMARS. R14 R14's diagnoses included dementia, psychotic disturbance, mood disturbance, and anxiety. R14's service plan dated July 11, 2022, indicated	01750		

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01750	Continued From page 30 staff would provide medication and treatment administration. R14's prescriber's orders dated June 5, 2023, included; -olopatadine HCl solution 0.2 % (eye allergies), instill one (1) drop in both eyes one (1) time a day for eye allergies. R14's prescriber's orders dated June 19, 2023, included: -Systane (dry eyes) 1 drop three (3) times daily, both eyes -transoprost (glaucoma- high eye pressure) one (1) drop every hs (hour of sleep), both eyes. R14's EMAR dated July 1, 2023, through July 12, 2023, included: -olopatadine HCl solution 0.2% one (1) drop, daily both eyes, 7:15 a.m. -travatan Z solution 0.004% (Travoprost (BAK Free) instill one (1) drop in both eyes one (1) time a day for glaucoma, 8:00 p.m. -Systane solution 0.4-0.3 % (polyethyl glycol-proply glycol) instill one (1) drop in both eyes three times a day for dry eyes; 8:00 a.m., 2:00 p.m., 8:00 p.m. On July 11, 2023, at 9:07 a.m., the surveyor observed ULP-O administer olopatadine 0.2 % into both of R14's eyes. ULP-O stated, "will start out with one of your eye drops." ULP-O administered nasal spray, scalp medication and left to get a scissors to open a pain patch. ULP-O took the oral medications with her. ULP-O returned and completed oral medication administration. ULP-O instilled Systane solution into both of R14's eyes. Directly following the above observation ULP-O	01750		

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01750	Continued From page 31 stated R14's EMAR did not contain any information regarding waiting between eye medication adding, waiting was taught in medication training and waiting five minutes in between eye drops was "standard." ULP-O said "they (staff)" have a window to administer medications, one hour before and one hour after the time on the EMAR. On July 11, 2023, at 11:15 a.m., registered nurse (RN)-K stated R14's EMAR lacked specific instructions for eye drops, adding "it" was in their training (waiting five minutes in between eye drop administration.) On July 12, 2023, at approximately 11:45 a.m., CNS-B stated specific instructions for eye drop administration would not be in any resident's EMARS. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN would developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 32 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 the steps of the medication administration process was followed for one of four unlicensed personnel (ULP-I); and failed to ensure insulin was administered per the manufacturer's instructions for one of one resident (R2) whom received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: MEDICATION ADMINISTRATION PROCESS On July 11, 2023, at 7:58 a.m., the surveyor observed ULP-I prepare R11's oral medication, eye medication, and ear medication. ULP-I took the medications to R11's room and administered them with proper technique. ULP-I left R11's room and returned the eye medication and ear	01760		

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01760	Continued From page 33 medication to the locked medication cabinet in the caregiver's office. ULP-I gathered equipment to take R11's vital signs. The surveyor did not observe ULP-I document R11's medication administration. On July 11, 2023, at 8:16 a.m., ULP-I stated he didn't document medication administration right away because he was "trying to get vitals done, to clear everything". ULP-I said he forgot about it, adding he "thought" she (R11) was coming to the common's area. On July 11, 2023, at 10:23 a.m., registered nurse (RN)-K stated the five rights of medication administration should be followed, documentation should be done as soon as medications are given, staff should "check" save. RN-K added if documentation was not completed right away that information could be lost and there was no reason to wait for vital signs to document. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated June 17, 2022, indicated staff would document each task immediately after that task had been performed. FOLLOWING MANUFACTURE'S INSTRUCTIONS R2's diagnoses included diabetes, dementia, agitation due to dementia, major depressive disorder, and anxiety. R2's service plan, dated July 30, 2021, indicated services included medication administration. R2's provider's orders dated July 7, 2023, included Lantus SoloStar (long-acting insulin) subcutaneous injection solution (pen) inject 18	01760		

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01760	Continued From page 34 units one (1) time per day. On July 11, 2023, at 10:14 a.m., the surveyor observed ULP-J check R2's electronic medication record (EMAR) and remove R2's Lantus insulin pen (a multiple dose pen shaped injector device used for insulin administration) from the locked medication cabinet. ULP-J cleaned the tip of the pen with an alcohol wipe, applied needle, and primed the pen (removed air bubbles from the needle, to ensure the needle was open and working). ULP-J dialed the pen to 18 units and asked ULP-O to verify dose. ULP-J went to R2's side and got on a knee and explained the process to ULP-O, find upper belly, "grab", push and count to five (5). The surveyor did not observe ULP-J clean R2's abdomen prior to using the insulin pen. Directly following the above observation ULP-J stated she "forgot to wipe off R2's stomach". On July 11, 2023, at 10:26 a.m., RN-K stated ULPs should clean the area prior to insulin administration with alcohol wipes. The manufacturer's instructions for the use of Lantus insulin pens, dated 2022, directed for the insulin site be cleaned with an alcohol swab prior to injection. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated before performing the procedures, the RN had instructed the unlicensed personnel in the proper methods to administer the medication, treatment and therapy and the unlicensed personnel had demonstrated the ability to competently follow the procedures.	01760		

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01760	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

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01790	Continued From page 36 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one ULP (ULP-G) was trained and had demonstrated competency to prepare and give medications for residents having	01790		

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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
01790	Continued From page 37 unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 10, 2023, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Delegation of Medications to be given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has trained the ULP and determined the ULP to be competent to follow the procedures for giving medications to residents. The RN needs to have developed written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The licensee's policy lacked the written procedure to include: - the type of container or containers to be used for the medications appropriate to the provider's	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	07/12/2023

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01790	Continued From page 38 medication system; - how the container or containers must be labeled; - written information about the medications to be provided; and - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP. TRAINING AND COMPETENCY EVALUATIONS ULP-G was hired on March 20, 2023, to provide direct care services for the licensee's residents which included medication administration. On July 11, 2023, at 7:11 a.m., the surveyor observed ULP-G administer R4's scheduled morning medications. ULP-G's employee record lacked evidence to indicate ULP-G had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On July 11, 2023, at 11:41 a.m., RN-K stated the facility's unplanned time away policy was missing the content noted above. In addition, RN-K stated the facility does not train or complete competency testing for unplanned time away. If a resident has unplanned time away the ULP should contact the RN on-call and the RN will walk the ULP through the process via phone. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01880	Continued From page 39	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures. 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 assisted living with dementia care facility had two separate buildings as part of their license (Heartland building and Heritage building). HEARTLAND BUILDING On July 10, 2023, at 10:58 a.m., the surveyor reviewed the content of the medication refrigerator in the caregiver's office with unlicensed personnel (ULP)-F and confirmed the following medications. ULP- F stated the current temperature of the refrigerator was 45 degrees Fahrenheit (F) and the temperature should be at	01880		

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01880	Continued From page 40 42 degrees F. ULP-F said the overnight staff complete the refrigerator log. The temperature log dated July (no year) was reviewed with ULP-F which contained several dashes (-)'s. ULP-F stated she had no idea what the dashes indicated on the form. ULP-F confirmed the following: -2 unopened Victoza 18 milligram (mg)/3 millitliter (ml) (helps to lower blood sugar) pens for R1 -2 unopened Novolog 100 units/ml (short-acting) insulin pens for R1 -3 Basaglar 100 units/ml (long-acting) insulin pens for R1 -1 unopened Lorazepam (used to treat anxiety) 2 milligrams/milliliters (mg/ml) bottle for R7. The temperature log for Heartland building dated June 1, 2023, through June 31, 2023, indicated the following: -27 of 31 opportunities the temperature was recorded. -10 of 17 opportunities the temperatures were out of range and documented below 36 degrees F. -5 of 27 opportunities the temperature was recorded less than 32 degrees F. The manufacturer's instructions for Victoza dated November 16, 2017, indicated to store unopened Victoza in a refrigerator between 36-46 degrees F. Do not allow Victoza to freeze. The manufacturer's instructions for Novolog insulin dated January 2019, indicated to store unopened Novolog in a refrigerator between 36-46 degrees F. Do not allow Novolog to freeze. The manufacturer's instructions for Basaglar insulin dated July 2021, indicated to store unopened Basaglar insulin in the refrigerator between 36-46 degrees F. Do not allow Basaglar	01880		

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01880	Continued From page 41 to freeze. The manufacturer's instructions for Lorazepam oral concentrate dated 2022, directed to store at cool temperatures between 36 to 46 degrees F. HERITAGE BUILDING On July 10, 2023, at 11:55 a.m., the surveyor reviewed the content of the medication refrigerator in the caregiver's office with registered nurse (RN)-C. RN-C stated the current temperature of the refrigerator was 36 degrees F, adding the temperature should be below 40 degrees to 32 degrees F. RN-C confirmed the following: -1 glargine 100 units/ml (long-acting) insulin for R2 -1 bottle of acidophilus (probiotic/good bacteria) for R8 On July 10, 2023, at 12:22 pm., RN-C stated the temperature logs were kept in the communication log adding temperatures have not been "done" (taken) every day. RN-C looked at the temperature log and said the temperature should not be this cold. ULP-E was standing in the area and stated the refrigerator should be at 40 degrees. RN-C said when the temperature of the refrigerator was out of range a call should be made right away, adding "makes sense to me." The temperature log for Heritage building dated June 1, 2023, through June 31, 2023, indicated the following: -14 of 31 opportunities the temperature was recorded. -14 of 14 opportunities the temperatures were out of range and documented below 36 degrees F. -1 of 14 opportunities the temperature was recorded less than 32 degrees F.	01880		

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01880	Continued From page 42 On July 10, 2023, at 2:41 p.m., clinical nurse supervisor (CNS)-B stated refrigerator temperatures should be 41 or less, as she read the statement off the temperature log sheet when reviewing temperature logs. CNS-B said staff would "probably " go to (name) food safety staff. CNS-B was not sure if staff had informed the food safety staff about the refrigerator temperatures being out of range. CNS-B added the expectation would be to record temperatures every night, "no holes." The manufacturer's instructions for glargine insulin dated June 4, 2021, indicated to store unopened Humalog in a refrigerator between 36-46 degrees F. Do not allow glargine to freeze. The manufacturer's instructions for probiotics dated August 27, 2021, indicated to storing probiotics in the refrigerator may help keep the bacteria alive longer than storing them at room temperature. The licensee's Storage of Medications policy dated August 1, 2021, indicated the RN would provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. In addition, when secured storage of medication was necessary, the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 43 days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing legible information including the opened-on date for time sensitive medication for R16, R15, R1, R9, R10, R8. In addition, the licensee failed to monitor for expired medications for R10. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The assisted living with dementia care facility had two separate buildings as part of their license (Heartland building and Heritage building). HEARTLAND BUILDING	01890		

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01890	Continued From page 44 On July 10, 2023, at 11:04 a.m., the surveyor reviewed the content of the medication cabinets in the caregiver's office with unlicensed personnel (ULP)-F. TIME SENSITIVE MEDICATION R16 -opened Refresh (dry eyes) drops lacked the date the eye drops were opened and when the eye drops would expire. R15 -opened Genteal (dry eyes) drops lacked the date the eye drops were opened and when the eye drops would expire. On July 10, 2023, at 11:06 a.m., ULP-F stated R16's Refresh eye drops and R15's Genteal eye drops should have been dated for when opened and when they would expire. In addition, R15's eye drops had "4/25" handwritten on the bottle. ULP-F said she was not sure what that meant. R1 - opened Victoza 18 milligram (mg)/3 milliliter (ml) (used to help lower blood sugar) pen lacked the date the pen was opened and when the pen would expire. - opened Basaglar 100 units/ml (long-acting) insulin pen lacked the date the pen was opened and when the pen would expire. On July 10, 2023, at 11:12 a.m., ULP-F stated she "thought" Victoza was good for 30 days. ULP-F added there was no date written on the pen, and added she would look at the date on the pen itself to determine the expiration date. ULP-F stated R1's Basaglar pen did not have an open or expiration date written on the pen. ULP-F added	01890		

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01890	Continued From page 45 they used to have stickers they used on medications to write open/expiration dates on. ULP-F said they ran out of the stickers, and they had not been reordered. The manufacturer's instructions for Refresh eye drops dated September 17, 2016, noted to discard the bottle 30 days after opening. The manufacturer's instructions for Genteal eye drops dated September 2016, noted do not use more than 30 days after first opening. The manufacturer's instructions for Victoza dated June 12, 2023, noted do not use more than 30 days after first opening. The manufacturer's instructions for Basaglar insulin dated July 2021, noted throw away the pen you are using after 28 days, even if it still had insulin left in it. HERITAGE BUILDING On July 10, 2023, at 11:55 a.m., the surveyor reviewed the content of the medication cabinets in the caregiver's office with registered nurse (RN)-C confirming the following: TIME SENSITIVE MEDICATION -R9 opened Refresh drops lacked the date the eye drops were opened and when the eye drops would expire. -R10 opened Systane (dry eyes) drops lacked the date the eye drops were opened and when the eye drops would expire. The manufacturer's instructions for Systane eye	01890		

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01890	Continued From page 46 drops dated May 12, 2017, noted to discard the bottle 30 days after opening. LEGIBLE INFORMATION -R9's Refresh eye drops had a date written on the bottle however the date was not legible. RN-C added the date did not make sense. RN-C added the medication could be from another facility, adding she was a newer resident, but not "that new". -R10 Systane eye drop label was very difficult to read stated RN-C. RN-C said "PRN" (as needed or desired) could be made out and "7/17/21" was written on the bottle. -R2 Neosporin (eye infection) eye drop bottle was difficult to read, RN-C stated she could read "5/1/23" and was questioning if it came from the pharmacy that day. -R8 albuterol sulfate inhaler had "some" writing on the inhaler. RN-C stated, "not good, hard to read 7 of 20 something?" On July 10, 2023, at 12:14 p.m., RN-C stated medications should be dated "one seal is cracked" for eye drops and inhalers. EXPIRED MEDICATION R10 Systane eye drops expired February 2023. Directly after the above observation RN-C removed R10's Systane eye drops from the medication cabinet. On July 10, 2023, at 12:15 p.m., RN-C stated it was "fair" to say not dating medications was a widespread issue.	01890		

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01890	Continued From page 47 The licensee's Storage of Medications policy dated August 1, 2021, indicated until the medication was set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 48 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 10, 2023, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. The licensee's undated Discharged or Deceased Resident Roster, indicated R1 was admitted to the facility on December 28, 2022, and discharged on April 21, 2023. R1's diagnoses included Alzheimer's, anxiety, and weakness. R1's service plan dated April 18, 2023, indicated R1 received medication administration services. R1's Medication Administration Record (MAR) for	01910		

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01910	Continued From page 49 April 2023, indicated the resident received the following medications: -loperamide (anti-diarrheal) 2 milligram (mg) tablet daily -aspirin (heart health) 81 mg daily -atorvastatin calcium (treat high lipids) 20 mg by daily -Divalproex Sodium (for Alzheimer's) 125 mg tablets- four tablets daily -Donepezil Hydrochloride (for dementia behaviors) 10 mg daily -duloxetine hydrochloride (for depression) 30 mg daily -levothyroxine sodium (treat low thyroid levels) 75 micrograms (mcg) daily -lisinopril (treat high blood pressure) 5 mg daily -lorazepam (for agitation) 0.5 mg three times daily -melatonin (for insomnia) 3 mg daily -Seroquel (for agitation) 25 mg daily -Simvastatin (treat cholesterol) 40 mg daily -trazodone (for insomnia) 50 mg daily -vitamin D (supplement) 1 tablet daily -vitamin D3 (supplement) 50 mcg daily -Propranolol (treat hypertension) 40 mg twice daily -acetaminophen (treat pain) 650 mg twice daily -gabapentin (treat behaviors) 200 mg three times daily -risperidone (for Alzheimer's) 0.5 mg three times daily. R1's prescriber orders dated March 22, 2023, March 24, 2023, and April 18, 2023, respectively, included the above noted medications. R1's Progress Notes dated April 21, 2023, indicated R1 was discharged to a skilled nursing facility. R1's record lacked documentation for the	01910		

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01910	Continued From page 50 disposition of the following medications to include 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: -loperamide 2 mg -aspirin 81 mg -atorvastatin calcium 20 mg -Divalproex Sodium 125 mg -duloxetine hydrochloride 30 mg -lorazepam 0.5 mg -vitamin D tablets -vitamin D3 50 mcg On July 10, 2023, at 2:44 p.m., CNS-B stated R1's medication disposition sheet was not completed with all the medications. The licensee's Disposition or Disposal of Medication dated August 1, 2021, indicated staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medications and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=E	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	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 51 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for three of three residents (R3, R2, R12) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 10, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	07/12/2023

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01950	Continued From page 52 residents. R3 R3's diagnoses included dementia, chronic kidney disease (kidneys are damaged and can't filter blood effectively), and hypertension (high blood pressure). R3's service plan dated April 24, 2023, indicated staff assistance to allow sufficient time for dressing and undressing, however, did not specifically identify applying or removing compression stockings (TEDS) daily. R3's record lacked prescriber orders for compression stockings (TEDS). R3's record lacked specific instructions for unlicensed personnel (ULP) to notify the RN regarding TEDS when a problem arises. On July 11, 2023, at 8:56 a.m., the surveyor observed ULP-N put on R3's TEDS. On July 12, 2023, at 8:44 a.m., CNS-B stated R3's record lacked specific instructions for TEDS. R2 R2's diagnoses included diabetes, dementia, agitation due to dementia, major depressive disorder, and anxiety. R2's service plan, dated July 30, 2021, indicated staff would provide medication and treatment administration, however, did not specifically identify assist with blood sugar monitoring. R2's electronic medication record (EMAR) dated July 1, 2023, through July 10, 2023, noted: -blood sugar one time a day every Monday,	01950		

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01950	Continued From page 53 Wednesday, Friday for diabetes check. FASTING blood sugar three (3) times per week -blood sugar one (1) time a day every Tuesday, Thursday, Saturday, Sunday for blood sugar reading. On July 12, 2023, at 8:26 a.m., the surveyor observed ULP-J check R2's blood sugar level. R2's record lacked specific instructions for ULPs to notify the RN regarding R2's blood sugar levels, when to report to nursing or when a problem arises. On July 12, 2023, ULP-J stated they had a sheet to follow, when to report to nursing, posted on the inside of a locked cabinet in the caregiver's office. ULP-J went to the cabinet and opened it, "not there." ULP-J stated they received that information in training, adding, "I over report," adding the facility she worked at prior reported BS reading below 90. ULP-J stated the information was in the computer and looked for information. ULP-J explained she looks at other recent readings "look to see last couple, adding everyone is different", and would report if outside of what had been recorded. On July 12, 2023, at 7:50 a.m., RN-K flipped through several laminated pages hanging on the wall in the caregiver's office and produced a piece of paper that included when to report blood pressure, pulse, respiration, temperature, and blood sugar (fasting) to nursing. RN-K stated R2's record lacked specific instructions for blood sugar monitoring. R12 R12's diagnoses included dementia.	01950		

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01950	Continued From page 54 R12's service plan dated June 19, 2023, indicated staff would provide medication and treatment administration, however, did not specifically identify assist with CPAP (noninvasive ventilation breathing support through a face mask, nasal mask, or helmet). R12's POC (Plan of Care) Response History dated July 5, 2023, through July 11, 2023, included "resident has a CPAP that she needs assistance with each night to put on". R12's prescriber orders dated June 12, 2023, noted, CPAP, humidity heated, nasal pillow, nasal interface mask/pillow, headgear, chin strap, tubing with heating element, disposable filters, non-disposable filter, water chamber. "Lifetime". On July 11, 2023, at 6:13 a.m., the surveyor observed ULP-M turn off R12's CPAP machine, stating "she took it (CPAP) off about 4:00 a.m." R12's record lacked specific instructions for ULPs to notify the RN regarding CPAP when a problem arises. On July 11, 2023, at 3:27 p.m., RN-K stated R12's record was missing specific instructions for R12's CPAP machine. RN-K said they were going to retrain all staff for it, adding family brought it in on "that day" and nursing came in and trained some staff. The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated June 17, 2022, indicated each treatment provided would have procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments.	01950		

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01950	Continued From page 55 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for three of four residents (R3, R12, R11) recieving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01960		

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01960	Continued From page 56 found to be pervasive). The findings include: During the entrance conference on July 10, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R3 R3's diagnoses included dementia, chronic kidney disease (kidneys are damaged and can't filter blood effectively), and hypertension (high blood pressure). R3's service plan dated April 24, 2023, indicated staff assistance to allow sufficient time for dressing and undressing. R3's record lacked prescriber orders for compression stockings (TEDS). On July 11, 2023, at 8:56 a.m., the surveyor observed unlicensed personnel (ULP)-N put on R3's TEDS. R3's record lacked documentation of R3's TEDS being put on and taken off by staff daily. On July 12, 2023, at 8:44 a.m., CNS-B stated R3's record had no documentation of staff putting on or taking off R3's TEDS. R12 R12's diagnoses included dementia. R12's service plan dated June 19, 2023, indicated staff would provide medication and treatment administration, however, did not specifically identify assist with CPAP.	01960		

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01960	Continued From page 57 R12's prescriber's orders dated June 12, 2023, noted, CPAP, humidity heated, nasal pillow, nasal interface mask/pillow, headgear, chin strap, tubing with heating element, disposable filters, non-disposable filter, water chamber. "Lifetime". On July 11, 2023, at 6:13 a.m., the surveyor observed ULP-M turn off R12's CPAP machine, stating "she took it (CPAP) off about 4:00 a.m." R12's POC (Plan of Care) Response History record dated July 5, 2023, through July 11, 2023, included columns labeled; applied, removed, resident not availability, resident refused, not applicable: -July 5, 2023, 21:02 (9:02 p.m.) resident refused -July 6, 2023, 5:54 a.m., applied; 20:46 (8:46 p.m.) not applicable -July 7, 2023, 5:52 a.m., resident refused; 22:31 (10:31 p.m.) resident refused -July 8, 2023, 5:26 a.m., removed; 21:24 (9:24 p.m.) applied -July 9, 2023, 5:44 a.m., applied; 22:40 (10:40 p.m.) applied -July 10, 2023, 6:12 a.m., removed -July 11, 2023, 5:23 a.m., removed On July 11, 2023, at 3:27 p.m., RN-K stated R12's record was missing documentation for R12's CPAP machine. RN-K said they (facility) were going to retrain all staff for it, adding family brought it in on "that day" and nursing came in and trained some staff. R11 R11's diagnoses included dementia, unspecified asthma, mood disturbance, anxiety, migraine, and insomnia.	01960		

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01960	Continued From page 58 R11's Service Plan, dated November 8, 2023, indicated staff would provide medication and treatment administration, however, did not specifically identify assist with oxygen monitoring/administration. R11's prescriber's orders dated May 27, 2023, included: -02 (oxygen) at 2 liters (L) via NC (nasal cannula-a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) as needed for saturation less than 90%, as needed -full set of vitals, AM (morning) and PM (evening) shift, Notify RN of any abnormalities, 02 less than 90%, elevated temperature, etc, two (2) times a day for respiratory infection monitoring. On July 11, 2023, at 7:58 a.m., the surveyor observed ULP-I complete scheduled medication administration to R11. R11's electronic task check off sheet dated July 1, 2023, through July 10, 2023, included: -oxygen saturation 5:00 p.m., and included documentation of service July 1, 2, 3, 4, 7, 8, 9, 10. R11's task check off sheet did not include documentation for July 5, 2023, and July 6, 2023. On July 12, 2023, at 11:53 a.m., the surveyor requested R11's June task check off sheet. RN-K stated she did not know how to retrieve that information, however she said no documentation should be missed. RN-K said R11's record was missing required documentation. The licensee's Documentation of Medication, Treatment, and Therapy Management Services	01960		

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01960	Continued From page 59 dated June 17, 2022, indicated all staff would appropriately document all medications, treatments, and therapy management services provided to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded orders were maintained for one of three residents (R3) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01970		

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01970	Continued From page 60 The findings include: During the entrance conference on July 10, 2023, at 11:03 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R3's diagnoses included dementia, chronic kidney disease (kidneys are damaged and can't filter blood effectively), and hypertension (high blood pressure). R3's service plan dated April 24, 2023, indicated staff assistance to allow sufficient time for dressing and undressing. On July 11, 2023, at 8:56 a.m., the surveyor observed unlicensed personnel (ULP)-N put on compression stockings (TEDS) for R3. R3's record lacked prescriber order for TEDS. On July 12, 2023, at 8:44 a.m., CNS-B stated R3's record did not have an order for TEDS. The licensee's Individualized Medication, Treatment, and Therapy Management dated June 17, 2022, indicated treatments were to be administered as prescribed and treatment plans must be updated when there are changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 61 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 record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 10, 2023, at approximately 1:50 p.m. with Maintenance Director (MD)-D on the hazard vulnerability assessment for the physical environment of the facility.	02040		

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02040	Continued From page 62 During interview, MD-D verified that the licensee had done a hazard vulnerability assessment for the risks of the physical environment on and around the property but nothing on mitigation of these risks. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=F	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 storage of cleaning supplies and personal products. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for one of two oxygen tanks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	02310		

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02310	Continued From page 63 a large portion or all of the residents). The findings include: The assisted living with dementia care facility had two separate buildings as part of their license (Heartland building and Heritage building). HEARTLAND BUILDING On July 10, 2023, at 10:45 a.m., the surveyor observed a laundry room with the door open. Under the sink were two (2) partial jugs of Clorox bleach under a laundry sink, and a bottle of Shout stain remover hanging from a wire rack above the washing/dryer. On July 10, 2023, at 10:47 a.m., the surveyor observed an open bathroom near the commons area with a container of Freebreeze (room deodorant) in plain sight. Residents were seated in the commons area. There were three (3) cans of Arrid deodorant in the unlocked bathroom. On July 10, 2023, at approximately 11:00 a.m., the surveyor observed three boxes of alcohol prep pads sitting on a desk in the unlocked caregiver's office and an opened bottle of hydrogen peroxide in an unlocked cabinet. On July 10, 2023, at 11:40 a.m., during a tour of the Heartland building with licensed assisted living director (LALD)-A, LALD-A stated the Freebreeze and the Arrid deodorants should be locked up and had been locked up, "baby lock". On July 10, 2023, at 11:45 a.m., LALD-A stated the bleach under the sink, in an open laundry area was "not a good sign". LALD-A removed the bleach.	02310		

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02310	Continued From page 64 HERITAGE BUILDING On July 10, 2023, at 11:50 a.m., during a tour of the Heritage building with LALD-A the surveyor observed eight cans of Arrid deodorant in an opened bathroom, five of the containers did not have caps, three were capped. LALD-A stated the deodorant should be locked up. On July 10, 2023, at approximately 11:55 a.m., the surveyor observed a container of Shout stain remover hanging up on a wire rack in the opened laundry room. LALD-A stated the Shout should have been locked up. On July 10, 2023, at approximately 12:00 p.m., the surveyor observed a can Suave hair spray unlocked and cans of Arrid deodorant in three of five drawers unlocked. Directly after the above observation LALD-A stated all residents at the facility have the diagnosis of dementia or a cognitive diagnosis, adding that is all the facility admits. LALD-A stated all chemicals should be locked up. On July 10, 2023, at approximately 12:01 p.m., the surveyor observed several two (2) packs of alcohol wipes in the open caregiver's office. On July 10, 2023, at 12:15 p.m., registered nurse (RN)-K stated, "doors are open so everything should be under lock and key." On July 10, 2023, at 12:21 p.m., unlicensed personnel (ULP)-E stated she took the alcohol wipes out "this" morning to show a new staff, adding normally they are kept in a unlocked drawer. CLOROX	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21568	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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 65 Safety Data Sheet dated June 12, 2015, indicated precautionary statements, immediately call a poison center or doctor, if swallowed: rinse mouth. Do NOT induce vomiting; -this chemical is considered hazardous by the 2012 OSHA (Occupational Safety and Health Administration) Hazard Communication Standard; -store locked up -causes severe skin burns and serious eye damage -wear protective gloves, protective clothing, face protecting, and eye protection such as safety glasses -although not expected heart conditions or chronic respiratory problems such as asthma, chronic bronchitis, or obstructive lung disease may be aggravated by exposure to high concentrations of vapor or mist -call a poison control center or doctor immediately for treatment advice -handle in accordance with good industrial hygiene and safety practice. Wash hands after direct contact. Do not wear product-contaminated clothing for prolonged periods. Remove and wash contaminated clothing before re-use. Do not eat, drink, or smoke when using this product. SHOUT TRIPLE-ACTING LAUNDRY STAIN REMOVER Material Safety Data Sheet dated June 19, 2006, indicated the following: -eye, may cause, mild eye irritation flush immediately with plenty of water for at least 15-20 minutes. If irritation persists, get medical attention -skin, prolonged or exposure contact may cause, irritation rinse with plenty of water -ingestion, immediately drink 1-2 glasses of water or milk. Seek immediate medical attention.	02310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 66 ALCOHOL PREP PADS Drug Facts printed on the sterile alcohol prep pads, undated, indicated the following: -active ingredient: isopropyl alcohol 70% -warning, for external use only: -flammable, keep away from fire or flame Do not use; -in the eyes or over large areas of the body -longer than one (1) week unless directed by a doctor -do not use with electrocautery procedures -stop use and ask a doctor if condition persists for more than 72 hours or gets worse. HYDROGEN PEROXIDE Hazardous Substance Fact Sheet dated May 2016 indicated hydrogen peroxide noted is unstable and an explosion risk. Hydrogen peroxide is on the Special Health Hazard Substance List. In addition, workplace controls and practices noted, "very toxic chemicals, or those that are reproductive hazards or sensitizers, required expert advice on control measures if a less toxic chemical cannot be substituted. Control measures include (1) enclosing chemical processes for severely irritating and corrosive chemicals, (2) using local exhaust ventilation for chemicals that may be harmful with a single exposure, and (3) using general ventilation to control exposures to skin and eye irritants; -label process containers; -provide employees with hazard information and training; -monitor airborne chemical concentrations; -uses engineering controls if concentrations exceed recommended exposure levels; -provide eye wash fountains and emergency showers;	02310		

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PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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 67 -wash or shower if skin comes in contact with a hazardous material; -always wash at the end of the worksite; -change into clean clothing if clothing becomes contaminated; -do not take contaminated clothing home; -get special training to wash contaminated clothing; -do not eat, smoke, or drink in areas where chemical are being handled, processed or stored; and -wash hands carefully before eating, smoking, drinking, applying cosmetics or using the toilet. FREEBREEZE (room deodorizer) Label printed on the Freebreeze can, undated, indicated the following: -caution use only as directed. Keep out of reach of children and pets -do not puncture or incinerate container -do not spray towards face. If eye contact occurs, rinse well with water. If irritation persists, get medical attention. Material Safety Data Sheet dated June 12, 2006, noted: -eye contact: mild eye irritant -ingestion: possible mild gastrointestinal irritation with nausea, vomiting and/or diarrhea -do not spray toward face. If eye contact occurs, rinse well with water -skin contact: prolonged skin contact or instillation into the eye may result in transient, superficial effects similar to those produced by mild toilet soap -inhalation: intentional misuse by deliberately concentrating and inhaling pressurized product may be harmful or fatal. Inhalation of high concentrations of ethanol vapor may cause irritation of the eyes, and respiratory tract, drowsiness and fatigue.	02310		

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PIONEERCARE - MEMORY COTTAGES	1317 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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02310	Continued From page 68 SUAVE Max Hold Hairspray Label printed on the Suave can, undated, indicated the following: -can cause serious injury or death -avoid spraying in eyes -contents under pressure -keep out of reach of children -use only as directed -inhaling the contents can be harmful or fatal. ARRID Extra Dry Deodorant Label printed on the Arrid can, undated, indicated the following: -use only as directed, intentional misuse by deliberately inhaling the content can be harmful or fatal -keep out of reach of children, if swallowed, get immediate help, call Poison Control Center right away -keep away from face and mouth to avoid breathing it -avoid spraying in eyes, if accidental eye contact occurs wash with water OXYGEN STORAGE On July 12, 2023, at 7:40 a.m., the surveyor observed one oxygen tank secured in a hand wheeled cart, and one oxygen tank unsecured in RN-K's office. Directly following the above observation RN-K stated the unsecured oxygen tank was a "trainer" tank and it was empty. On July 12, 2023, at 10:44 a.m., the surveyor picked up the unsecured oxygen tank in RN-K's office and learned the tank was not "empty." Directly after learning the above information	02310		

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02310	Continued From page 69 regarding the partially filled oxygen tank RN-K stated, "My training one is empty, I don't know anything about that one." RN-K added she did not know if the oxygen tank was a resident's or whose tank it was, "I have no idea." On July 12, 2023, at 11:51 a.m., clinical nurse supervisor (CNS)-B stated her expectation was oxygen tanks should be secured. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410		

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02410	Continued From page 70 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for four of four residents (R2, R4, unidentified resident, R5) while receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: PERSONAL CARES On July 11, 2023, at 7:26 a.m., the surveyor observed R2 lying in bed, in a room he shared with a roommate who was resting in bed. There was a curtain that hung from the ceiling (divider) which was approximately three quarters of the way closed positioned between the two beds. There was a window on the outside wall of the room with the curtain not fully closed. The surveyor observed unlicensed personnel (ULP)-J go to R2's closet and give R2 the choice of shirts to wear for the day. ULP-J assisted R2 to sit on	02410		

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02410	Continued From page 71 the side of the bed and offered R2 a washcloth to wash his face. ULP-J removed R2's shirt and washed R2's back, applied lotion, placed deodorant under R2's arms, and applied a shirt. ULP-J asked R2 to stand and pulled R2's pants and brief down to around his ankles. ULP-J asked R2 if he wanted to use a warm washcloth to clean his peri area, "your front". R2 declined the offer, adding he needed to hold onto his walker. ULP-J cleaned R2's peri area front and back. ULP-J asked R2 if he wanted to dry his "front" and he accepted the towel. ULP-J prepared a dry place on the bed for R2 to sit while she removed his pants, brief, and socks. ULP-J applied lotion to R2's legs and dressed his lower body. The surveyor did not observe ULP-J fully close the divider curtain or close the curtains on the window. On July 11, 2023, at 9:26 a.m., ULP-J stated there were two curtains in R2's room. ULP-J said she should have pulled the one curtain the "whole way", adding, it goes across (blocking the outside window also). ULP-J stated R2 can get "pretty upset," and that R2 does not like the curtain closed. ULP-J added R2 was "good this morning." On July 11, 2023, at 10:25 a.m., registered nurse (RN)-K stated the expectation was that curtains should be pulled (closed) for everyone, "even if they get upset." INSULIN ADMINISTRATION On July 11, 2023, at 10:14 a.m., the surveyor observed R2 sitting at a dining room table in the commons area. An unidentified resident was sitting next to him. The surveyor observed ULP-J prepare R2's insulin pen (a multiple dose pen shaped injector device used for insulin	02410		

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02410	Continued From page 72 administration). ULP-J went to R2's right side and got on her knee and turned R2's chair. ULP-J was explaining the process to ULP-O, stating, "find the belly, upper part and grab it. Push the insulin pen and count to 5." The surveyor did not observe ULP-J offer R2 to move to a different area, private, or ask R2 or the unidentified resident if the insulin could be given at the table. On July 11, 2023, at 10:26 a.m., RN-K stated giving insulin at the table has been a "conversation" and direction at the facility was, not everyone there was bothered by it [administration at table], "just the way it has been." RN-K said residents should be offered or given privacy with insulin administration. On July 12, 2023, at approximately 7:30 a.m., ULP-J stated she "used" to ask R2 everyday if she could give his insulin while he was sitting at the table, and he always said "ok." ULP-J added she no longer asks him daily. DELEGEGATED TASKS ULP-G On July 11, 2023, at 7:38 a.m., the surveyor observed ULP-G complete R4's vital signs at the community dining room table with other residents present. ULP-G completed a blood pressure reading, temperature reading, heart rate reading and oxygen saturation reading on R4. The surveyor did not observe ULP-G ask R4 or the other residents present at the table if it was okay to complete the vital signs at the table. On July 11, 2023, at 7:43 a.m., ULP-G stated she would normally ask the resident or other residents present if it was okay to complete vital signs prior to completing the task.	02410		

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02410	Continued From page 73 ULP-H On July 11, 2023, at 9:10 a.m., the surveyor observed ULP-H complete an unidentified resident's vital signs at the community dining room table with other residents present. ULP-H completed a blood pressure reading, temperature reading, heart rate reading, respirations reading and oxygen saturation on the unidentified resident. The surveyor did not observe ULP-H ask the unidentified resident or the other residents present at the table if it was okay to complete the vital signs at the table. ULP-N On July 11, 2023, at 10:13 a.m., the surveyor observed ULP-N complete R5's vital signs in the community living room with other residents present. ULP-N completed a blood pressure reading, temperature reading, heart rate ready, respiration reading and oxygen saturation reading on R5. The surveyor did not observe ULP-N ask the other residents prior to completed R5's vital signs if it was okay to complete in the living room. On July 11, 2023, at 10:18 a.m., ULP-H and ULP-N stated they did not ask other residents present during vital signs as they have known from the past the residents are "okay" with it. On July 11, 2023, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated it is faster to do vital signs in the community areas instead of bringing the resident to a private area, however, they should ask the resident and surrounding residents first before completing the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/10/23*
Time: 14:54:15
Report: 7935231121

Food and Beverage Establishment Inspection Report

Location:
Pioneercare - Memory Cottages
1317 South Mabelle Avenue
Fergus Falls, MN56537
Otter Tail County, 56

Establishment Info:
ID #: 0038118
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189989677
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

DO NOT STORE RAW SHELL EGGS OVER READY TO EAT FOOD (PRODUCE/PASTA SALAD).

Comply By: 07/10/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

KITCHENS ARE DOMESTIC. IF LEFTOVERS ARE SAVED AND COOLED TO BE REHEATED, KITCHEN MUST BE COMMERCIAL AND ALL EQUIPMENT MUST MEET ANSI STANDARDS.

Comply By: 07/10/23

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 193 Degrees Fahrenheit - Location: Salisbury Steak
Violation Issued: No

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

Type: Full
Date: *07/10/23*
Time: 14:54:15
Report: 7935231121
Pioneercare - Memory Cottages

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

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

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

5. Reminder eggs that are not pasteurized must only be used for single serving, immediate service and cooked to approved temperature.

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

I acknowledge receipt of the MN Department of Health inspection report number 7935231121 of 07/10/23.

Certified Food Protection Manager: Diane Carlson

Certification Number: 78036 Expires: 04/11/24

Signed: _____
Establishment Representative

Signed: 7935
7935

651-201-4500
health.foodlodging@state.mn.us