Electronically Delivered

August 15, 2023

Licensee
Madonna Summit Of Byron
551 Byron Main Court Northeast
Byron, MN 55920

RE: Project Number(s) SL32270015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 26, 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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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

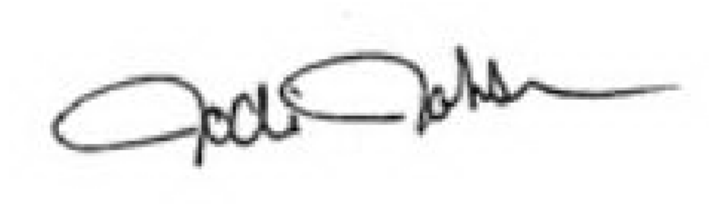
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	32270	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA SUMMIT OF BYRON	551 BYRON MAIN CT NE BYRON, MN 55920

(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: SL32270015-0 On July 24, 2023, through July 26, 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 45 active residents; 25 were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: 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 26, 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 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 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 establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of four unlicensed personnel (ULP-E, ULP-C) between resident contact, medication administration and meal service. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E On July 25, 2023, at 7:10 a.m. ULP-E was observed leaving a resident's room following medication administration and without completing hand hygiene, entered R10's room, set up his topical (put on skin) medication, applied gloves, applied the medication, removed the gloves, documented on her tablet, locked the medication	0 510		

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0 510	Continued From page 3 cupboard, left R10's room and went to the dining area to assist another resident by serving coffee. At 7:43 a.m., ULP-E was observed to enter R6's room, applied gloves, touched multiple surfaces, set up an insulin pen for administration, assisted with insulin administration, removed gloves, and then documented on her tablet. ULP-E left R6's room and returned to the dining room, applied clean gloves and assisted with serving juices and coffee to residents in the dining room. At 8:20 a.m., ULP-E was observed to return to R6's room, applied clean gloves, touched multiple surfaces, set up R6's second insulin pen injection, assisted with administration of insulin, removed her gloves and documented the medication administration on her tablet. ULP-E then returned to the dining area and applied clean gloves. ULP-E failed to consistently perform proper hand hygiene following the use of gloves or prior to contact between residents. On July 25, 2023, at 1:15 p.m. registered nurse (RN)-B stated she expected staff to wash/sanitize their hands between resident rooms, prior to serving meals/drinks and between the use of gloves. ULP-C On July 25, 2023, at 7:50 a.m. ULP-C was observed performing a blood sugar check and setting up/administering medications for R3 including oral medications, eye drops, insulin, nasal spray, and an inhaler. ULP-C applied gloves prior to performing R3's blood sugar check and administering her medications. Without removing their gloves, ULP-C administered R3's oral medications, which she poured into her hand and gave one at a time to the resident, placing it in her mouth, then the resident would take a drink	0 510		

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0 510	Continued From page 4 of water independently and swallow. ULP-C then administered the resident's eye drops, nasal spray, inhaler, and insulin wearing the same gloves. Once finished at 8:07 a.m., ULP-C removed her gloves and proceeded to R5's room to prompt her for breakfast and to administer medication. ULP-C did not cleanse her hands after removing her gloves or prior to entering R5's room. ULP-C applied gloves and set-up R5's Miralax (laxative) for administration. Once set-up, ULP-C removed her gloves and assisted R5 into the dining room for breakfast. ULP-C brought R5's Miralax in water out to the dining room table and placed in front of the resident. ULP-C then exited the dining room for a short time prior to the breakfast meal. At 8:25 a.m., the breakfast meal was delivered to the secure memory care unit and placed in the steam table. ULP-I and ULP-K were observed to wash their hands and apply gloves prior to assisting with the meal service. ULP-C returned to the memory care unit dining area and applied gloves without washing/sanitizing their hands and began to assist with the meal service. At one point ULP-C touched the garbage can lid when moving it. ULP-I then informed ULP-C she would need to remove her gloves and wash her hands. ULP-C then washed her hands and applied clean gloves and finished assisting with the meal process. At 8:41 a.m., the surveyor asked ULP-C when she would cleanse her hands during the medication administration process and resident cares. ULP-C stated she cleansed her hands prior to entering a resident's room and also when leaving the room. ULP-C stated she cleansed her hands prior to entering R5's room and setting up her Miralax or "thought" she did. On July 25, 2023, at 2:06 p.m. registered nurse (RN)-B stated the expectation for hand hygiene	0 510		

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0 510	Continued From page 5 and glove use would be to cleanse hands any time staff walk in and out of a room, after glove removal, when handling food, assisting with eating, and serving/preparing food. Also, between residents or after a task such as providing pericare (after glove removal). The licensee's Hand Hygiene policy dated March 2, 2022, indicated hands washing would be performed between client cares and whenever direct physical contact with a client took place. Use of gloves did not replace hand washing. Hands would be washed or decontaminated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a fall with significant injury for one of three residents (R8). This practice resulted in a level two violation (a	0 620		

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0 620	Continued From page 6 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: R8's diagnoses included Parkinson's disease (a chronic degenerative disorder of the central nervous system that mainly affects the body's motor/movement system), dementia and depression. R8's Service Plan dated September 17, 2022, included medication administration, assistance with dressing and bathing, and stand by assistance with ambulation with a walker. The licensee's fall report dated February 9, 2023, at 4:45 p.m. indicated a fall occurred in the resident's bathroom, where the resident was found on the floor. Injury type: pain. Occurrence contributed or resulted in hospital admission. Investigation analysis note read "Resident found on left side on floor in bathroom, facial grimacing when moving arms, unable to state where pain was, sent to ER [emergency room] for evaluation and was admitted with 7th and 8th rib fx [fracture] to left side. Will review service plan upon return for new intervention." Root cause identified both altered gait/balance and resident safety awareness deficit. R8's Clinical View Report (nurse progress note) indicated the following entries: -dated February 10, 2023, at 1:49 p.m. read "Fall	0 620		

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0 620	Continued From page 7 February 9, 2023, at 4:45 p.m.-Resident found laying on floor on left side in bathroom-resident had not pants or underwear on at time of fall-staff noted resident had been incontinent of large amount of urine as noted by large urine spot on chair-resident had her pants hanging on towel rack in bathroom. VS [vital signs] as follows: B/P [blood pressure]-141/77, P [pulse]-67, RR [respiratory rate]-16, T [temperature]-97.4. This nurse assessed resident and resident able to move lower extremities without increase pain or discomfort but did have facial grimacing when attempting to move arms and was unable to state where she hurt d/t [due to] DX [diagnoses]:dementia [brain changes/deterioration causing cognitive/physical decline]. Daughter was updated and resident was sent to [hospital] via ambulance for evaluation. Resident was admitted to hospital with DX: FX [fracture to 7th and 8th ribs on left side. Fax sent to primary MD [medical doctor] regarding fall. -dated February 10, 2023, at 4:48 p.m. read "This nurse spoke to nurse at [hospital] today and nurse stated resident was having therapy and being treated for pain to 7th and 8th rib fx. Will call Monday a.m. to check on resident's condition and discharge plan." -dated February 17, 2023, at 4:46 p.m. read "This nurse has called for an update on resident every other day over this past week and spoke to daughter regarding resident's condition-resident has been having difficulty standing with assist of 1 and needing some assist with eating-having pain due to fx ribs and her cognition has declined. Will call Mon a.m. for update- nurse stated resident may need to be discharged to a higher level of care." -dated February 22, 2023, at 1:49 p.m. read "This nurse spoke with nurse at St. Mary's Hospital and it was noted that resident's transfer abilities wax	0 620		

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0 620	Continued From page 8 and wane and is needing assist of 2 at times and cognition has also declined and is not eating well-decision made that resident needs to move to a higher level of care and she will discharge from hospital to a long term care setting." R8's MAARC report dated February 12, 2023, at 1:30 p.m. indicated the same information as written in R8's fall report dated February 9, 2023. The licensee failed to immediately (within 24 hours), report to MAARC, a fall with significant injury. On July 25, 2023, at 12:45 p.m. regional director of housing services/registered nurse (RDHS/RN)-G stated she had checked with the clinical nurse supervisor (CNS) (currently on vacation) regarding the time delay for the MAARC report and indicated R8's plan of care was followed and R8 was independent with mobility. She stated the CNS and licensed assisted living director (LALD)-A had filed the MAARC report on the date indicated and was uncertain why it was delayed. The licensee's Vulnerable Adult Reporting and Investigation policy dated March 3, 2022, indicated "Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director, and that person will complete an incident report. -If the incident appears to be suspected abuse, neglect or financial exploitation, LALD or designee will immediately make a report to MAARC. -"Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the	0 620		

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0 620	Continued From page 9 incident occurred. - If it is unclear based whether maltreatment has occurred, and investigation into the incident will begin immediately. -If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 10 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began providing direct care services for the licensee on May 24, 2022. ULP-C's record lacked an annual performance review. On July 25, 2023, at 12:45 p.m. human resources director (HRD)-F stated the licensee recognized employee date of hire anniversary as their due date for annual training performance reviews, and confirmed ULP-C's file lacked an annual performance review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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	32270	A. BUILDING: _____ B. WING _____	07/26/2023

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0 660	Continued From page 11	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed health history and symptom screen for two of two employees (unlicensed personnel (ULP)-D, ULP-C) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for one of two employees (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 660		

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0 660	Continued From page 12 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB risk assessment dated November 8, 2022, indicated the licensee was a low risk. ULP-D ULP-D was hired June 8, 2023, to provide direct care services. On July 25, 2023, at 9:35 a.m. ULP-D was observed to complete a blood sugar check and administer medications to R1. ULP-D's employee record included a quantiFERON (blood) test dated May 9, 2023, but lacked evidence of TB history and symptom screening as required. On July 25, 2023, at 12:45 p.m. human resources director (HR)-F stated although ULP-D had the quantiFERON testing, he could not find record of tuberculosis history and symptom screening having been completed at the time of hire. ULP-C ULP-C was hired May 24, 2022, to provide direct care services. On July 25, 2023, at 7:50 a.m. ULP-C was observed preparing and administering medications to R3. ULP-C's employee record lacked evidence of TB history and symptom screening and either a	0 660		

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0 660	Continued From page 13 two-step TST or QuantiFERON test as required. On July 25, 2023, at 1:00 p.m. HRD-F stated ULP-C did not complete a TB symptom screen or QuantiFERON test at time of hire nor to current date. The licensee's Tuberculosis Program for Associates dated June 22, 2023, indicated all associates and volunteers that were sharing 10 hours of air space or more with the residents each week would be included in the program. Every new associate would begin by filling out the Personal Risk Assessment and Symptom Review. This would be reviewed by the infection preventionist (IP) to determine if further testing is required, or if the associate indicated they had a high risk condition. For communities in MN, MO and ND and WI, or those that have a positive risk assessment, a tuberculin skin test (TST) or QuantiFERON test, depending on community preference, would be performed on newly hired associates. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 14 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 680		

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0 680	Continued From page 15 During the entrance conference on July 24, 2023, at 11:00 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's emergency preparedness plan last reviewed August 1, 2022, lacked the following required content: - a description of the population served by the licensee; - procedure for tracking staff and residents; - development of policies/procedures to address: - the system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - use of volunteers; - a communication plan that included: - names and contact information for resident physicians; - contact information for the ombudsman and licensing agency; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act -emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy - EP training and testing program; - EP training program for staff (including documentation of training provided); and	0 680		

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0 680	Continued From page 16 - EP testing/annual testing requirements. On July 26, 2023, at 12:53 p.m. licensed assisted living director (LALD)-A confirmed the emergency procedures book they utilized was for all the corporate facilities and were just starting to make it specific to this licensee. LALD-A was unable to provide evidence of the above information. The licensee's Disaster Planning and Emergency Preparedness Plan policy revised June 28, 2023, indicated: 8. Plan is to address d. A system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. e. The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. g. The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=C	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated,	0 690		

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0 690	Continued From page 17 and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in three of three residents' records (R1, R2, R3) were authenticated by the title of the person making the entry. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Resident evaluations (comprehensive assessments), Siderail/Grab/Mobility/Assist Bar Assessments, Fall Risk Assessments, Medication Management Assessments and Person Centered Wellness Questionnaires dated January 25, 2023, April 20, 2023, and July 12, 2023, included the clinical nurse supervisor's electronic signature but lacked her credentials of registered nurse (RN). R1's POC (Point Of Care) Task History Report (Task record) dated July 1, 2023, through July 24, 2023, included the "Caregiver" names of staff who had completed the assigned tasks, but lacked the staff's credentials. R1's electronic medication record (eMAR) dated	0 690		

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0 690	Continued From page 18 July 1, 2023, through July 24, 2023, included 13 staffs' names and initials, but lacked the credentials of resident assistant (RA) for eight of these staff. R2 R2's Medications Administration History and Treatments Administration History records dated July 1, 2023, through July 24, 2023, had a list of staff identified (that had administered medications/treatments) at the bottom of the last page with columns for initials and name/title. 15 staff initials and names were identified; however, titles were lacking on 11 of the identified staff members. R2's ADL (activities of daily living) Administration History record dated July 1, 2023, through July 24, 2023, had a list of staff identified (that had assisted with ADLs) at the bottom of the page with columns for initials and name/title. Seven staff initials and names were identified; however, titles were lacking on four of the identified staff members. R2's initial admission assessment dated February 7, 2023, 14-day assessment dated February 21, 2023, and change of condition assessment dated May 17, 2023, were not authenticated with the title of the person completing the assessment. R2's Clinical View Report (progress notes) dated February 7, 2023, through June 24, 2023, included the name, but lacked the title of the individual making the entry. R2's POC (Point of Care) History Report (Task record) dated July 1, 2023, through July 24, 2023, included the "Caregiver" names of staff who had	0 690		

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0 690	Continued From page 19 completed the assigned tasks, but lacked the staff credentials. R3 R3's Medication Administration Record dated July 1, 2023, through July 24, 2023, had a list of staff identified (that had administered medications) at the bottom of the last page with columns for initials and name/title. Eighteen staff initials and names were identified; however, titles were lacking on 12 of the identified staff members. R3's 90-day assessment dated June 21, 2023, and change of condition assessments dated March 27, 2023, and February 28, 2023, were not authenticated with the title of the person completing the assessment. R3's Clinical View Report dated January 5, 2023, through June 20, 2023, included the name, but lacked the title of the individual making the entry. R3's POC History Report dated July 1, 2023, through July 24, 2023, included the "Caregiver" names of staff who had completed the assigned tasks, but lacked the staff credentials. On July 25, 2023, at 11:45 a.m. regional director of housing services/registered nurse (RDHS/RN)-G stated with a change in the electronic medical record (EMR), not all staff credentials transferred. Furthermore, she stated all resident records containing staff initials or names should be authenticated with title/credentials and would look further into the system and correct. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 690		

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0 690	Continued From page 20 (21) days	0 690		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete required employee evacuation drills. 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: An interview and record review were conducted on July 26, 2023, between approximately 11:00 a.m. and 12:15 p.m. with the maintenance technician (MT)-H and the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plans, fire safety and evacuation training, and evacuation drills for the facility. The licensee failed to provide records to support that employee training on the facility fire safety and evacuation plans was completed upon hiring and at least twice per year thereafter as required by statute. The licensed assisted living director (LALD)-A explained that employees were trained during the evacuation drills and upon hire, but did not have documented training records available for review. The licensee failed to provide records to support	0 810		

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0 810	Continued From page 22 that annual resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had been completed as required by statute. The licensed assisted living director (LALD)-A explained that during resident meetings, procedures for fire safety and evacuation were discussed, but did not have documented training records available for review. The licensee failed to provide records to support that evacuation drills had been completed every other month as required by statute. Evacuation drill documentation was not provided for January and February of 2023 and October and November of 2022. It was noted by survey staff that the year was not recorded on several of the evacuation drill records. The evacuation drill frequency of twice per year per shift with at least one evacuation drill every other month was not met. These deficient conditions were verified by the licensed assisted living director (LALD)-A and the maintenance technician (MT)-H on July 26, 2023, at approximately 12:10 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 23 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

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01500	Continued From page 24 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began providing direct care services for the licensee on May 24, 2022. ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and	01500		

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	32270	A. BUILDING: _____ B. WING _____	07/26/2023

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01500	Continued From page 25 procedures; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques, the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfection environmental surfaces; and reporting communicable disease; and - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On July 26, 2023, at 11:49 a.m. regional director of housing service/registered nurse (RDHS/RN)-G stated she spoke with the human resources director who indicated they assigned annual training with the staff's anniversary date in mind. RDHS/RN-G further stated ULP-C's annual training should have been completed by her anniversary date. The licensee's Educare Assisted Living & Memory Care/Minnesota Annual Training Checklist - Caregiver form created by Educare dated May 3, 2021, indicated: Total credits required annually/8 Subject Matter included: - Infection control - Dementia training/two hours Problem solving Communication - Organization policies & procedures No further information was provided.	01500		

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01500	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for a change in condition for one of three residents (R3) related to falls.	01620		

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01620	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked evidence the RN had conducted an assessment of the resident for a change in condition related to falls, including assessment for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. R3 currently resided in the secure memory care unit with diagnoses including dementia, diabetes mellitus, atrial fibrillation, and insomnia. R3's Service Plan dated February 28, 2023, indicated R3 received bathing, dressing, grooming, medication administration, blood sugar checks, assistance applying and removing compression stockings, housekeeping, and laundry. The service plan further indicated the resident received limited assist with toileting up to three times a day. May have some incontinence, assist with changing incontinent products up to three times in 24 hours. Staff directed to check in on resident in AM, PM, and in evening ensuring she is going to the bathroom and checking if incontinent brief is soiled. R3's record indicated the resident moved from the assisted living facility into the secure memory	01620		

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01620	Continued From page 28 care unit on March 27, 2023, due to cognitive decline and the need for increased supervision. The record further indicated R3 had falls on January 6, 2023, and March 7, 14, 19, and 20, 2023, prior to moving into the secure memory care unit. R3's change of condition assessment dated March 27, 2023, indicated the resident occasionally falls - three to six times a year and to report increasing evidence of unsteadiness or other safety concerns. The assessment further indicated the resident did not require additional safety checks outside of required housing checks. R3's incident reports and progress notes following the move to the secure memory care unit indicated: - April 2, 2023, at 4:15 a.m. resident found sitting on the floor in room near the bathroom with walker in front of her. Recently had been seen per therapy. The record did not include any new interventions. - April 20, 2023, at 5:00 a.m. resident found sitting on the floor beside her bed. Staff had checked on resident 10 minutes prior to the fall and she was sitting on her bed. Resident sustained a rub/bump to her forehead from the carpet. Resident was cognitively at baseline per nursing assessment. The incident report indicated the occurrence increased the need for monitoring or intervention as a result of temporary harm. R3's record did not include new interventions or increased monitoring due to the fall. - May 10, 2023, at 4:45 a.m. resident was found sitting on floor next to a chair with the walker beside her. R3's record did not include a root cause analysis, new interventions, or increased	01620		

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01620	Continued From page 29 monitoring due to the fall. - May 27, 2023, at 4:30 a.m. resident found sitting on the floor beside her bed. R3's walker was at the end of the bed. The resident had attempted to stand up and lost her balance. R3's record did not include new interventions or increased monitoring due to the fall. - June 5, 2023, at 3:30 a.m. resident found sitting on the floor in front of her dresser and walker was by her recliner. Reminders were given to the resident to use walker, but she forgets and gets upset when you remind her. R3's record did not include new interventions or increased monitoring due to the fall. R3's record lacked evidence of documented assessment by the RN for change in condition related to the falls as above, including review for potential causative factors and to determine specific interventions to minimize the risk for future falls and potential injury. R3's 90-day assessment dated June 21, 2023, indicated the resident occasionally falls - three to six times a year, and to report increasing evidence of unsteadiness or other safety concerns. The assessment further indicated the resident did not require additional safety checks outside of required housing checks. Review of R3's record indicated the resident had fallen 10 times since January 6, 2023. On July 26, 2023, at 10:38 a.m. RN-B stated staff were directed to remind R3 to use her walker and ensure she had her walker with her when ambulating. RN-B stated R3 was not on any enhanced checks nor toileting plan, though there were other residents that received those services. RN-B further stated R3 was independent with toileting, though staff were to check to make sure	01620		

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01620	Continued From page 30 she went to the bathroom or was incontinent and needed a brief change. This occurred three times a day in the morning, afternoon, and evening, and verified there was not a check on the night shift. RN-B stated clinical nurse supervisor (CNS)-J would have been the nurse who followed up on R3's falls, though was currently on vacation and unavailable to interview. RN-B reviewed R3's falls since transferring to the secure memory care unit and stated they followed a pattern related to time of day. RN-B further stated R3's record did not include evidence of new interventions to prevent further falls. The licensee's Initial and On-going Assessments of Residents policy revised July 1, 2021, indicated: 1. On-Going Assessments of Residents. a. The RN will re-assess each resident on an on-going basis. b. The RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. c. The RN will reassess the resident if the resident has a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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01640	Continued From page 31 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 24, 2023,	01640		

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01640	Continued From page 32 at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents as prescribed. R2's diagnoses included neurocognitive disorder with Lewy bodies, atrial fibrillation, and edema. R2's physician order dated July 13, 2023, indicated; torsemide (a diuretic/water pill) 20 milligrams (mg). Take four tablets (80 mg total) by mouth two times a day and metolazone (a diuretic/water pill) 2.5 mg. Take 0.5 tablets (1.25 mg total) by mouth as directed 1.25 mg every three days as needed for weight 168 lb (pounds) or more. On July 25, 2023, at 7:38 a.m. unlicensed personnel (ULP)-I stated she has already given R2 her medications, though still needed to get her weight. ULP-I stated R2 was weighed daily and her "cut off" was 168 lbs. ULP-I further stated yesterday (July 24, 2023) R2 weighed 169 lbs and therefore received a PRN (as needed) medication to remove fluid. R2's Service Plan dated May 17, 2023, indicated the resident was weighed weekly every Monday before meals, in the same clothing, on the same scale. On July 25, 2023, at 2:53 p.m. registered nurse (RN)-B stated R2 was weighed daily due to fluid retention. RN-B reviewed R2's service plan and stated it should have been revised to reflect the need for daily weights. The licensee's Service Plan Policy revised July 2021, indicated: Revisions to the Service Plan: 1. Each resident's service plan is reviewed by the	01640		

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01640	Continued From page 33 RN, therapist, or other licensed health professional as follows: b. Whenever changes are needed to the services to be provided because of a change in the resident's condition, after receipt of new or revised orders from the resident's provider or other prescribing provider, following an incident, or return from a hospital or skilled nursing facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01640		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-C) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for three of three residents (R6, R7, R3) observed during insulin administration. The licensee further failed	01750		

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01750	Continued From page 34 to ensure administration of an inhaler was completed per manufacturer instructions for one of one resident (R3) and failed to ensure one of seven residents (R5) consumed medication administered. 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: R6 R6's diagnoses included diabetes mellitus without complications (the body's inability to adequately manage blood sugar). R6's Service Plan dated April 27, 2023, indicated R6 received services to include staff assistance with insulin set up and injections. R6's wife managed the remainder of his medication administration. R6's provider orders dated June 1, 2023, indicated insulin glargine 100 units/milliliter (ml), inject 24 units under the skin every morning, and Lyumjev KwikPen 100 unit/ml, inject 12-16 units under the skin as directed. 16 units with breakfast, 12 units with lunch and 14 units with evening meal. On July 25, 2023, at 7:43 a.m. ULP-E assisted R6 with his glargine Kwikpen insulin. ULP-E	01750		

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01750	Continued From page 35 removed the pen from R6's locked medication drawer, obtained a new needle, removed the Kwikpen cover and attached the new needle, but failed to wipe the Kwikpen tip with an alcohol wipe prior to placing a new needle. At 8:20 a.m., ULP-E assisted R6 with his Lyumjev KwikPen insulin injection. Again, ULP-E removed the insulin Kwikpen from R6's locked medication drawer, obtained a new needle, removed the Kwikpen cover and attached the new needle without first wiping the Kwikpen tip with an alcohol wipe prior to placing a new needle. R7 R7's diagnoses included diabetes mellitus and heart failure. R7's Service Plan dated September 20, 2022, included the services of medication administration and insulin injections. R7 was independent with blood sugar checks. R7's provider orders dated May 15, 2023, indicated Novolog Flexpen 100 units/ml; give 32 units subcutaneously at 8:00 a.m., give 28 units at 12:00 p.m., and give 30 units at 5:00 p.m. Additionally, R7 had an order for Basaglar insulin 100 units/ml, give 57 units twice daily. On July 25, 2023, at 8:15 a.m. ULP-E was observed to set up R7's Novolog insulin pen. ULP-E obtained the insulin pen from R7's locked medication drawer in her apartment, removed the insulin pen cap and attached a new needle to the insulin pen tip but failed to wipe the insulin pen tip with an alcohol wipe prior to placing the new needle. On July 25, 2023, at 1:30 p.m. registered nurse (RN)-B stated she expected ULP to follow the	01750		

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01750	Continued From page 36 proper procedure as taught in medication training, which included wiping the insulin pen tip prior to placing a clean needle on the insulin pen. The licensee's undated, Insulin Pen procedure indicated to remove the (insulin) pen cap and clean the tip with a sterile alcohol wipe, then attach a new needle to the pen. R3 R3's diagnoses included diabetes mellitus and asthma. R3's Service Plan dated February 28, 2023, indicated the resident received services including medication administration. The service plan also indicated R3 was able to administer insulin on her own or with cues or set up. R3's signed physician orders dated June 19, 2023, included the following orders: Lantus Solostar U-100 insulin 100 unit/ml (units per milliliter). Inject 27 units under the skin every morning. Route: subcutaneous (under the skin). Fluticasone propionate (Flovent inhaler) 110 mcg/actuation (micrograms per actuation) inhale two puffs by mouth twice a day. On July 25, 2023, at 7:50 a.m. ULP-C was observed preparing and administering R3's medications which included Lantus insulin and fluticasone propionate inhaler. When preparing R3's Lantus insulin pen, ULP-C removed the cap from the pen and attached a new needle to the port. ULP-C did not cleanse the end of the port with alcohol prior to attaching the needle. ULP-C dialed the insulin pen to two units, wasted the two units, then dialed the pen to the prescribed 27 units. When administering R3's insulin, ULP-C did not offer or ask R3 if she wanted to administer	01750		

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01750	Continued From page 37 her own insulin. ULP-C cleansed R3's abdomen with an alcohol prep pad, injected the insulin into the resident's abdomen, then immediately removed the pen/needle from the resident's abdomen once administered. Prior to administering R3's inhaler, ULP-C did not shake the inhaler. R3's inhaler had an attached extension on the end of the inhaler. ULP-C instructed R3 to put the end of the extension in her mouth and to inhale when ULP-C pushed down on the inhaler. ULP-C administered one puff while instructing R3 to inhale, then immediately administered the second puff. ULP-C did not wait in between puffs. ULP-C also did not offer or instruct R3 to rinse her mouth after administering the inhaler. When interviewed immediately following R3's medication administration, ULP-C stated she had not been trained to apply alcohol to the end of the insulin port prior to applying a new needle. R5 R5's diagnoses included dementia with anxiety and constipation. R5's Service Plan dated March 28, 2023, indicated the resident received services including medication administration. R5's signed physician orders dated March 1, 2023, included an order for polyethylene glycol 3350 powder (a laxative); 17 gram/dose; amount: 17 grams; oral. Use once daily as needed for constipation. On July 25, 2023, at 8:07 a.m. ULP-C was observed entering R5's room and setting up the resident's polyethylene glycol and pouring the powder into a glass of water for consumption. ULP-C then assisted R5 from the resident's room	01750		

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01750	Continued From page 38 to the dining room and brought the glass of water with the polyethylene glycol with her. Once R5 was seated at the dining room table, ULP-C set the glass with the medication in front of the resident. ULP-C then proceeded to assist other residents and then helped with serving the breakfast meal. R5 was seated at a large table with several other residents in the secure memory care unit. ULP-C did not prompt R5 to consume the water with the polyethylene glycol, nor did she observe the resident to ensure she took the medication or that another resident didn't attempt to consume. On July 25, 2023, at 2:06 p.m. RN-B stated expectation with insulin pen administration would be to cleanse the insulin pen port with an alcohol swab prior to attaching the needle. RN-B further stated expectation once insulin was administered would be to hold the insulin pen against the skin for five to 10 seconds prior to removing the needle from the skin. With administration of an inhaler, RN-B stated expectation would be for staff to instruct the resident to breath in and hold breath for three to five seconds and wait in between administering each puff. With administration of specifically a Flovent inhaler, would expect staff to instruct resident to rinse mouth after administration. RN-B also stated with medication administration of R5's polyethylene glycol, would expect the staff administering the medication to stand by and observe the resident until she had consumed it. The Lantus SoloStar pen manufacturer's instructions dated 2022, indicated: Step 2. Attach the needle - Wipe the pen tip (rubber seal) with an alcohol swab. Step 5. Inject your dose	01750		

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01750	Continued From page 39 - Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) - Release the button and remove the needle from your skin. The Flovent HFA Instructions for Use revised August 2021, indicated: For correct use of your FLOVENT HFA inhaler, remember: The metal canister should always fit firmly in the plastic actuator. Shake the inhaler well for 5 seconds before each spray. Breathe in deeply and slowly to make sure you get all the medicine. Hold your breath for about 10 seconds after breathing in the medicine. Then breathe out fully. After each dose, rinse your mouth with water and spit it out. Do not swallow the water. 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 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 40 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were clarified and transcribed correctly per physician order for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 25, 2023, at 7:50 a.m. unlicensed personnel (ULP)-C was observed preparing and administering medications for R3. R3's oral medications had been set-up by a nurse in a weekly med minder that was kept locked in a drawer in the resident's room. ULP-C removed R3's AM med minder from the drawer, opened the Tuesday slot, and identified each of the pills against the medication administration record (MAR). The medications administered included (according to the MAR) amlodipine (used to treat high blood pressure) 2.5 milligrams (mg) daily, calcium with vitamin D3 (supplement) 600 mg/500 unit twice daily, and simethicone	01760		

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01760	Continued From page 41 (flatulence) 125 mg daily. The surveyor reviewed the MAR with ULP-C and questioned the order for amlodipine as it indicated: amlodipine 10 mg; amount to administer 2.5 mg. ULP-C stated the order was confusing and would ask the nurse about it. ULP-C then proceeded to administer R3's medications. R3's current signed physician orders dated June 19, 2023, included: amlodipine 2.5 mg tablet, take one tablet by mouth daily; calcium carbonate-vitamin D3 600 mg calcium-400 unit tablet, take one tablet by mouth two times a day; and simethicone 125 mg chewable tablet, chew one tablet four times a day as needed for flatulence. On July 25, 2023, at 2:06 p.m. registered nurse (RN)-B reviewed R3's MAR dated July 2023, and compared it with R3's current physician orders dated June 19, 2023. RN-B stated there were transcription errors on the MAR related to R3's amlodipine and calcium carbonate with vitamin D3 dosages, though the resident was receiving the correct dosage. RN-B further stated R3 was receiving simethicone scheduled daily rather than as needed per physician orders. The licensee's Medication, Treatment, and Therapy Administration - Licensed and Unlicensed Personnel policy revised July 2021, indicated: C. Medications, treatments, or therapies will be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route e. Right dose f. Right reason	01760		

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01760	Continued From page 42 E. Medication, treatment, or therapy will be administered as directed by the resident's Provider order, the service plan and MAR. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's record lacked signed prescriber orders for a medication administered by the licensee.	01820		

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01820	Continued From page 43 R3's diagnoses included asthma. R3's Service Plan dated February 28, 2023, included medication administration. R3's Medication Administration Record (MAR) dated July 2023, included fluticasone propionate nasal spray suspension; 50 mcg/actuation (micrograms per actuation). Two sprays into each nostril daily. On July 25, 2023, at 7:50 a.m. unlicensed personnel (ULP)-C was observed administering medications to R3 including Fluticasone propionate nasal spray. R3's current signed physician orders dated June 19, 2023, did not include an order for fluticasone propionate nasal spray. On July 25, 2023, at 2:06 a.m. registered nurse (RN)-B reviewed R3's current physician orders dated June 19, 2023, and stated it did not include an order for R3's fluticasone propionate nasal spray. RN-B stated the nasal spray was on the residents signed annual orders from January 2023, but not on the current orders. The licensee's Medication, Treatment, and Therapy Administration - Licensed and Unlicensed Personnel policy revised July 2021, indicated: E. Medication, treatment, or therapy will be administered as directed by the resident's Provider order, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01820		

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01820	Continued From page 44 days	01820		
01880 SS=E	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 resident refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations in two of two resident (R6, R7) refrigerators. Additionally, the licensee failed to ensure insulin was securely stored in two of two resident (R6, R7) apartments/refrigerators. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 24, 2023, at 11:00 a.m. during entrance conference, registered nurse (RN)-B stated resident medications were securely stored in locked cabinets in each apartment.	01880		

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01880	Continued From page 45 R6 R6's diagnoses included diabetes mellitus without complications (the body's inability to adequately manage blood sugar). R6's Service plan dated April 27, 2023, indicated R6 received services to include staff assistance with insulin set up and injections. R6's wife managed the remainder of his medication administration. R6's Medication Management plan dated April 27, 2023, indicated it was the licenee's standard of practice to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage for controlled substances. On July 25, 2023, at 7:43 a.m. ULP-E assisted R6 with setting up and administration of his glargine Kwikpen insulin. ULP-E stated additional insulin pen cartridges were kept in the resident's refrigerator door. On July 25, 2023, at 1:00 p.m. the surveyor observed no temperature monitoring had been performed and observed the following contents in R6's refrigerator: -Lyumjev Kwikpen-three pens -Lantus- eight pens R7 R7's diagnoses included diabetes mellitus and heart failure. R7's Service Plan dated September 20, 2022, included the services of medication administration and insulin injections. R7 was independent with blood sugar checks.	01880		

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01880	Continued From page 46 R7's Medication Management Plan dated September 20, 2022, indicated it was the standard of practice of Benedictine to store medications in the resident's room with a locked cupboard and utilizing a secondary locked storage for controlled substances. On July 25, 2023, at 8:15 a.m. ULP-E was observed to set up R7's Novolog insulin pen. ULP-E stated additional insulin pen cartridges were kept in the resident's refrigerator door. On July 25, 2023, at 1:05 p.m. the surveyor observed no temperature monitoring had been performed and observed the following contents in R7's refrigerator: -Aspart-two pens Additionally, the surveyor observed the insulin pens stored in R6 and R7's refrigerators were not securely stored. On July 25, 2023, at 1:30 p.m. registered nurse (RN)-B stated none of the refrigerators in resident rooms where temperature sensitive medications were stored would have refrigerator temperature monitoring completed and were not securely stored. Novolog Manufacturer's instructions dated 2022, 16.2 Recommended Storage Unused Novolog should be stored in a refrigerator between 2° and 8°C (Celsius) (36° to 46° Fahrenheit). Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze Novolog and do not use Novolog if it has been frozen. Novolog should not be drawn into a syringe and stored for later use. Prefilled cartridges or Novolog FlexPen and Novolog	01880		

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01880	Continued From page 47 FlexTouch: Once a cartridge or Novolog FlexPen or Novolog FlexTouch is punctured, it should be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. A Novolog FlexPen or Novolog FlexTouch or cartridge in use must NOT be stored in the refrigerator. Keep the Novolog FlexPen or Novolog FlexTouch and all Prefilled cartridges away from direct heat and sunlight. Unpunctured Novolog FlexPen or Novolog FlexTouch and Prefilled cartridges can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused Novolog FlexPen or Novolog FlexTouch and Prefilled cartridges in the carton so they will stay clean and protected from light. Lyumjev manufacturer's (Lilly) instructions dated 2022, indicated no refrigeration and use within 28 days when stored at room temperature. The licensee's Storage of Medications policy dated March 3, 2022, indicated the RN would recommend where medications should be stored understanding that our agency may not be able to control where and how a client stores his/her medication in their room. The RN would provide education to the client/client'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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 48	01890		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an insulin pen for two of three residents (R6, R7) included an opened date and failed to ensure medications bore an original or proper label for four of six residents (R1, R6, R7, R3) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R6 R6's diagnoses included diabetes mellitus without complications (the body's inability to adequately manage blood sugar). R6's Service plan dated April 27, 2023, indicated R6 received services to include staff assistance with insulin set up and injections. R6's wife	01890		

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01890	Continued From page 49 managed the remainder of his medication administration. On July 25, 2023, at 7:43 a.m. unlicensed personnel (ULP)-E assisted R6 with setting up and administration of his glargine Kwikpen insulin. ULP-E recognized the insulin pen as stored in R6's locked medication drawer did not indicate an opened date and did not include a proper label. ULP-E stated additional Kwikpens were stored in the labeled box in R6's refrigerator. R7 R7's diagnoses included diabetes mellitus. R7's Service Plan dated September 20, 2022, included the services of medication administration and insulin injections. R7 was independent with blood sugar checks. On July 25, 2023, at 8:15 a.m. ULP-E was observed to set up R7's Novolog insulin pen. ULP-E recognized R7's Novolog insulin pen as stored in R7's locked medication drawer lacked an opened date and lacked a proper label. ULP-E stated additional insulin pen cartridges were kept in a labeled box in R7's refrigerator. R1 R1's diagnoses included heart failure and atrial fibrillation (an irregular heart beat which increases the risk for blood clots) and diabetes mellitus (when the body cannot regulate blood sugar). R1's Service plan dated July 19, 2023, indicated R1 received services to include medication administration. On July 25, 2023, at 9:35 a.m. ULP-D was observed to administer oral medications and	01890		

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01890	Continued From page 50 apply a lidocaine 5% patch (used for pain control) to R1's lower right back. The lidocaine as stored in R1's locked medication drawer was kept in a Ziploc bag with only her name and the name of the medication written on it with a black marker. The lidocaine patch packaging did not include a proper label. On July 25, 2023, at 1:30 p.m. registered nurse (RN)-B stated she expected the ULP to write an open date for time sensitive medications such as insulin pens and understood the requirement for proper labeling for all resident medications and would develop an internal process or work with the facility designated pharmacy to obtain additional labels for medications which may be separated from the original packaging/label. R3 R3's diagnoses included diabetes mellitus and asthma. R3's Service Plan dated February 28, 2023, indicated the resident received assistance with medication administration. R3's signed physician orders dated June 19, 2023, included orders for Lantus Solostar U-100 insulin 100 unit/ml (units per milliliter). Inject 27 units under the skin every morning. Route: subcutaneous (under the skin). Fluticasone propionate 110 mcg/actuation (micrograms per actuation) inhale two puffs by mouth twice a day, and polyvinyl alcohol (artificial tears) 1.4% ophthalmic solution. Administer one drop into both eyes every morning. On July 25, 2023, at 7:50 a.m. ULP-C was observed preparing R3's medications for	01890		

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01890	Continued From page 51 administration. R3's Lantus Solostar insulin pen and Fluticasone propionate inhaler did not include a prescription label on the medication or in the medication cart. R3's artificial tears bottle was covered with a homemade label indicating to administer one drop in each eye, covering up the label on the bottle. ULP-C confirmed there was not a prescription label on the insulin pen, inhaler, and eye drops or in the medication cart. ULP-C stated she went by the electronic medication administration record (eMAR) for the dosing instructions. ULP-C then proceeded to administer R3's medications. On July 25, 2023, at 2:06 p.m. RN-B stated they did not have extra labels to keep with the insulin pens as multiple pens came in a box with one label on the box. RN-B stated she would expect staff to keep the box the inhaler came in with the prescription label with the inhaler. RN-B stated R3's artificial tears were purchased over the counter by family due to cost, and stated the bottle shouldn't have been covered with the homemade label to prevent visualization of the manufacturer label. The licensee's Storage of Medications policy dated March 3, 2022, indicated, until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. Novolog Manufacturer's instructions dated 2022,	01890		

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01890	Continued From page 52 indicated once a cartridge or Novolog FlexPen or Novolog was punctured/opened, it should be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Lyumjev manufacturer's (Lilly) instructions dated 2022, indicated no refrigeration and use within 28 days when stored at room temperature. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and	01940		

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01940	Continued From page 53 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included heart failure and atrial fibrillation (an irregular heart beat which increases the risk for blood clots) and diabetes mellitus (when the body cannot regulate blood sugar). R1's Service plan dated July 19, 2023, indicated R1 received assistance with thrombo-embolic deterrent stockings (TED) (compression type	01940		

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01940	Continued From page 54 stockings used to reduce chances for blood clot formation in the lower extremities). The Service Plan included the instructions to assist to put on in the a.m. and assist to take off at bedtime, rinse out stockings, towel dry, and to dry. Additionally, the Service plan included the treatment of daily blood sugar checks. R1's task record dated July 2023, included TED stocking assistance within the twice daily tasks of dressing and grooming. On July 25, 2023, at 7:10 a.m. unlicensed personnel (ULP)-E stated the late night staff had already placed R1's TED stockings earlier that morning when she was assisted with dressing. On July 25, 2023, at 9:35 a.m. ULP-D completed a blood sugar check for R1. ULP-D stated she was not aware of blood sugar parameters for R1. R1's Medication Administration Record (MAR) dated July 2023, indicated blood sugar checks daily from July 4, 2023, through July 25, 2023, with special instructions of "wipe finger with alcohol wipe and check blood sugar-record in electronic Medication Administration Record (eMAR)"; however the instructions lacked blood sugar parameters and when the ULP would need to contact the nurse. R1's Treatment Plan dated July 19, 2023, indicated the following: (1) The type of services that will be provided will be recorded in your eMAR or Services in Matrix (the licensee's electronic record program). (2) Documentation of specific resident instructions relating lo the treatments or therapy administration will be recorded in your eMAR or Services in Matrix.	01940		

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01940	Continued From page 55 (3) Identification of treatment or therapy tasks that will be delegated to unlicensed personnel in your eMAR or Services In Matrix. (4) Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) Any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy' lo prevent possible complications or adverse reactions. The treatment or therapy management record will be current with specific resident instructions and updated when there are any changes. Licensed nursing staff or competently trained unlicensed personnel will provide assistance with treatments or therapy as developed by the registered nurse. Records of treatments or therapy orders, treatments or therapy administration and specific instructions are maintained in the resident's permanent record. R1's record lacked blood sugar parameters and when ULP would need to contact the nurse for concerns with R1's blood sugar levels and concerns with R1's TED stockings. On July 26, 2023, at 10:20 a.m. registered nurse (RN)-B reviewed R1's record and indicated the licensee failed to include blood sugar parameters for R1. Additionally, R1's record/treatment plan lacked instructions for when ULP would contact nursing regarding concerns with R1's TED stockings. R2 R2's Service Plan dated May 17, 2023, indicated	01940		

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01940	Continued From page 56 R2 required assistance with compression stockings. The service plan directed staff to apply compression socks on in AM and remove at HS (hour of sleep/bedtime). Rinse out at HS and hang over towel bar to dry overnight. R1's task record dated July 2023, included compression stocking assistance within the twice daily tasks of dressing and grooming. R3 R3's Service Plan dated February 28, 2023, included assistance to apply compression socks in the AM and to take off at HS. Rinse out stockings, towel dry, hang to dry. The service plan also indicated staff checked R3's blood sugar once daily. R3's task record dated July 2023, included compression stocking assistance within the twice daily tasks of dressing and grooming. R3's MAR dated July 2023, included an order to check blood sugar daily at 8:00 a.m. The MAR included a box for staff to initial when completed and to document the blood sugar value. R3's record did not include evidence of blood sugar parameters for when to notify a nurse. R2 and R3's records lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services On July 25, 2023, at 2:06 p.m. RN-B reviewed R2 and R3's treatment plans and stated they did not include direction to staff of when to notify a nurse when problems arose with the resident's	01940		

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01940	Continued From page 57 compression stockings. RN-B also stated R3's record did not include blood sugar parameters to direct staff when to notify a nurse. The licensee's Treatment and Rehabilitative Therapy Management policy dated March 3, 2022, indicated the licensee would indicate procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, for one of three residents (R3).	01960		

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01960	Continued From page 58 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's current signed physician orders dated June 19, 2023, included an order for blood glucose testing twice daily. On July 25, 2023, at 7:50 a.m. unlicensed personnel (ULP)-C was observed performing a blood glucose check for R3. R3' Medication Administration Record (MAR) dated July 2023, included an order to check blood sugar daily at 8:00 a.m. On July 25, 2023, at 2:06 p.m. registered nurse (RN)-B reviewed R3's current physician orders and compared to R3's MAR. RN-B verified R3's blood sugar was only being checked daily and not twice a day per physician order. The licensee's Medication & Treatment Orders - Receiving, Implementing, Renewal and Re-ordering policy revised July 2021, indicated: To assure that medications and treatments are up-to-date and administered in accordance to provider order. A licensed nurse, licensed therapist or pharmacist ensure that medications and treatment orders (either in writing, verbally, or electronically) by an authorized provider are	01960		

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01960	Continued From page 59 transcribed into the medical record. 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 up to date written or electronically recorded orders were maintained for one of three residents (R1) receiving 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 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:	01970		

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01970	Continued From page 60 R1's diagnoses included heart failure and atrial fibrillation (an irregular heart beat which increases the risk for blood clots) and diabetes mellitus (when the body cannot regulate blood sugar). R1's Service plan dated July 19, 2023, indicated R1 received assistance with thrombo-embolic deterrent stockings (TED) (compression type stockings used to reduce chances for blood clot formation in the lower extremities). R1's task record dated July 2023, included TED stocking assistance within the twice daily tasks of dressing and grooming. On July 25, 2023, at 7:10 a.m. unlicensed personnel (ULP)-E stated the late night staff had already placed R1's TED stockings earlier that the morning when she was assisted with dressing. R1's record included a signed provider's order dated July 23, 2021, for TED stockings. The licensee failed to ensure the order for the treatment of TED stockings was renewed on an annual basis. On July 26, 2023, at 1:00 p.m. regional director of housing services/registered nurse (RDHS/RN)-G provided the surveyor with R1's TED stocking orders dated July 23, 2021, and indicated there was no evidence of an annual renewal of these orders. The licensee's Mediation and Treatment Orders-Receiving, Implementing, Renewal and Re-ordering policy dated March 3, 2022, indicated Medication and Treatment orders would be sent to the resident's authorized provider for signatures at least every 12 months, more	01970		

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01970	Continued From page 61 frequently if renew order was needed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	03000		

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03000	Continued From page 62 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a fall with significant injury for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	03000		

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03000	Continued From page 63 R8's diagnoses included Parkinson's disease (a chronic degenerative disorder of the central nervous system that mainly affects the body's motor/movement system), dementia and depression. R8's Service Plan dated September 17, 2022, included medication administration, assistance with dressing and bathing, and stand by assistance with ambulation with a walker. The licensee's fall report dated February 9, 2023, at 4:45 p.m. indicated a fall occurred in the resident's bathroom, where the resident was found on the floor. Injury type: pain. Occurrence contributed or resulted in hospital admission. Investigation analysis note read "Resident found on left side on floor in bathroom, facial grimacing when moving arms, unable to state where pain was, sent to ER [emergency room] for evaluation and was admitted with 7th and 8th rib fx [fracture] to left side. Will review service plan upon return for new intervention." Root cause identified both altered gait/balance and resident safety awareness deficit. R8's Clinical View Report (nurse progress note) indicated the following entries: -dated February 10, 2023, at 1:49 p.m. read "Fall February 9, 2023, at 4:45 p.m.-Resident found laying on floor on left side in bathroom-resident had not pants or underwear on at time of fall-staff noted resident had been incontinent of large amount of urine as noted by large urine spot on chair-resident had her pants hanging on towel rack in bathroom. VS [vital signs] as follows: B/P [blood pressure]-141/77, P [pulse]-67, RR [respiratory rate]-16, T [temperature]-97.4. This nurse assessed resident and resident able to move lower extremities without increase pain or	03000		

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03000	Continued From page 64 discomfort but did have facial grimacing when attempting to move arms and was unable to state where she hurt d/t [due to] DX [diagnoses]:dementia [brain changes/deterioration causing cognitive/physical decline]. Daughter was updated and resident was sent to [hospital] via ambulance for evaluation. Resident was admitted to hospital with DX: FX [fracture to 7th and 8th ribs on left side. Fax sent to primary MD [medical doctor] regarding fall. -dated February 10, 2023, at 4:48 p.m. read "This nurse spoke to nurse at [hospital] today and nurse stated resident was having therapy and being treated for pain to 7th and 8th rib fx. Will call Monday a.m. to check on resident's condition and discharge plan." -dated February 17, 2023, at 4:46 p.m. read "This nurse has called for an update on resident every other day over this past week and spoke to daughter regarding resident's condition-resident has been having difficulty standing with assist of 1 and needing some assist with eating-having pain due to fx ribs and her cognition has declined. Will call Mon a.m. for update- nurse stated resident may need to be discharged to a higher level of care." -dated February 22, 2023, at 1:49 p.m. read "This nurse spoke with nurse at St. Mary's Hospital and it was noted that resident's transfer abilities wax and wane and is needing assist of 2 at times and cognition has also declined and is not eating well-decision made that resident needs to move to a higher level of care and she will discharge from hospital to a long term care setting." R8's MAARC report dated February 12, 2023, at 1:30 p.m. indicated the same information as written in R8's fall report dated February 9, 2023. The licensee failed to immediately (within 24 hours), report to MAARC, a fall with significant	03000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA SUMMIT OF BYRON	551 BYRON MAIN CT NE BYRON, MN 55920

(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
03000	Continued From page 65 injury. On July 25, 2023, at 12:45 p.m. regional director of housing services/registered nurse (RDHS/RN)-G stated she had checked with the clinical nurse supervisor (CNS) (currently on vacation) regarding the time delay for the MAARC report and indicated R8's plan of care was followed and R8 was independent with mobility. She stated the CNS and licensed assisted living director (LALD)-A had filed the MAARC report on the date indicated and was uncertain why it was delayed. The licensee's Vulnerable Adult Reporting and Investigation policy dated March 3, 2022, indicated "Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director, and that person will complete an incident report. -If the incident appears to be suspected abuse, neglect or financial exploitation, LALD or designee will immediately make a report to MAARC. -"Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the incident occurred. - If it is unclear based whether maltreatment has occurred, and investigation into the incident will begin immediately. -If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC. No further information was provided.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32270	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA SUMMIT OF BYRON	551 BYRON MAIN CT NE BYRON, MN 55920

(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
03000	Continued From page 66 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/26/23*
Time: 08:01:05
Report: 8044231228

Food and Beverage Establishment Inspection Report

Location:
Madonna Summit Of Byron - Main Kitchen
551 Byron Main Ct Ne
Byron, MN55920
Olmsted County, 55

Establishment Info:
ID #: 0038790
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073153608
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

No air gap with floor sink for dishwasher discharge line.

Comply By: 08/09/23

5-200B Plumbing: cross connections

5-203.14I ***** Priority 1 *****

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

No pressure relief device installed for chemical dispenser connected to mop sink faucet.

Comply By: 08/09/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes,

coffee bean grinders, and water vending equipment.

Mold in ice machine.
Comply By: 07/27/23

Surface and Equipment Sanitizers

Lactic Acid: = 704 ppm at Degrees Fahrenheit
Location: Third sink
Violation Issued: No

Hot Water: = at 160.1 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37.6 Degrees Fahrenheit - Location: Beef roast in WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36.4 Degrees Fahrenheit - Location: Boiled eggs in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

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

HRD inspection conducted with Nursing Evaluators Deb Jacobson and Wendy Buckholz. Inspection report reviewed on site with Food Service Supervisor, Jason.

Type: Full
Date: *07/26/23*
Time: 08:01:05
Report: 8044231228
Madonna Summit Of Byron - Main Kitchen

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231228 of 07/26/23.

Certified Food Protection Manager: Jill A. Crowson

Certification Number: FM112213 Expires: 07/19/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Jason

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/26/23*
Time: 09:28:00
Report: 8044231229

Food and Beverage Establishment Inspection Report

Location:
Madonna Summit Of Byron - Memory Care
551 Byron Main Ct Ne
Byron, MN55920
Olmsted County, 55

Establishment Info:
ID #: 0038790
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073153608
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.

2-100 Supervision

2-101.11 ***** Priority 2 *****

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

No air gap with drain for dishwasher discharge line.
Comply By: 08/09/23

Surface and Equipment Sanitizers

Hot Water: = at 160.0 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37.9 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Type: Full
Date: *07/26/23*
Time: 09:28:00
Report: 8044231229
Madonna Summit Of Byron - Memory Care

Food and Beverage Establishment Inspection Report

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231229 of 07/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Jason

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/26/23*
Time: 09:37:27
Report: 8044231230

Food and Beverage Establishment Inspection Report

Location:
Madonna Summit Of Byron - Assisted Living
551 Byron Main Ct Ne
Byron, MN55920
Olmsted County, 55

Establishment Info:
ID #: 0038790
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073153608
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

No air gap with drain for dishwasher discharge line.

Comply By: 08/09/23

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39.6 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

Type: Full
Date: *07/26/23*
Time: 09:37:27
Report: 8044231230

Food and Beverage Establishment Inspection Report

Madonna Summit Of Byron - Assisted Living

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231230 of 07/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Jason

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/26/23*
Time: 09:44:32
Report: 8044231231

Food and Beverage Establishment Inspection Report

Location:
Madonna Summit Of Byron - Independent Living
551 Byron Main Ct Ne
Byron, MN55920
Olmsted County, 55

Establishment Info:
ID #: 0038790
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073153608
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

No air gap with drain for dishwasher discharge line.

Comply By: 08/09/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Sign not posted for handwashing sink next to microwave.

Comply By: 07/26/23

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/26/23*
Time: 09:44:32
Report: 8044231231

Food and Beverage Establishment Inspection Report

Madonna Summit Of Byron - Independent Living

Process/Item: Cold Holding
Temperature: 37.5 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: Upright
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231231 of 07/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Jason

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us