

Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

April 18, 2023

Licensee Ksms Our House LLC 204 14th Street Northwest Austin, MN 55912

RE: Project Number(s) SL30630015

Dear Licensee:

On April 5, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 12, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 12, 2022 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on September 12, 2022, found not corrected at the time of the April 5, 2023, follow-up survey and/or subject to penalty assessment are as follows:

# 1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)

The details of the violations noted at the time of this follow-up survey completed on April 5, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

### **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.

### **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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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.

Sincerely,

Jodi Johnson, Supervisor State Evaluation Team Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 3879

St. Paul, MN 55101-3879

Telephone: 507-344-2730 Fax: 651-281-9796

**JMD** 

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
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NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0-7/00	
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
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{0 000}	Initial Comments		{0 000}			
	In accordance with 144G.08 to 144G.9 been issued pursual Determination of which corrected requires a requirements provisindicated below. Which contains several ite of the items will be compliance.  INITIAL COMMENTA Project SL3063001  On April 4, 2023, the Minnesota Department revisit at the above orders issued pursual January 11, 2023, were 16 residents: the Assisted Living	PROVIDER LICENSING DER  Minnesota Statutes, section 5 this correction order(s) has ant to a survey.  hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute was, failure to comply with any considered lack of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assitag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144G subd. 1, 2, and 3.	oftware. to sted signed column Statute ct of the listed in encies" s the he state This as eyors' rection. DING OF THIS ON FOR TATE d for scope	
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	(4) keep the physic	cal environment, including				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		30630	B. WING			5/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN. I	ST NW VIN 55912			
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{0 800}	walls, floors, ceiling systems, and equip good repair and ope health, safety, comf residents in accordarepair program.	, all furnishings, grounds, ment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and ent is not met as evidenced	{0 800}			
{01640} SS=D	that services are first facility shall finalize (b) The service plan include a signature facility and by the reagreement on the service plan must be resident reassessming facility must provide about changes to the and how to contact Long-Term Care and for Mental Health and (c) The facility must services required by (d) The service plan must be entered into including notice of a when applicable.  (e) Staff providing set the current written services are plan to the current written services.	calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting ervices to be provided. The e revised, if needed, based on ent under subdivision 2. The entire information to the resident deficient of Ombudsman for defice of Ombudsman for deficient and provide all yether current service plan. In and the revised service plan of the resident record, a change in a resident's fees ervices must be informed of	{01640}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	I ST NW MN 55912			
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{01640}	by: Based on interview licensee failed to er revised with change residents (R8).  This practice results violation that did no safety but had the president's health or cause serious injury was issued at an islimited number of real limited number of situation has occurr.  The findings include The licensee lacked for the treatment set blood sugar checks.  R8's diagnoses included an order for R8's Medication Ad April 2023, identified Check blood sugar symptoms (low blood shakiness, confusion resident a glass of jurse on call for fur R8's Service Plan in R8's R8's R8's R8's R8's R8's R8's R8's	and record review, the asure the service plan was as in services for one of three and in a level two violation (and tharm a resident's health or obtential to have harmed a safety, but was not likely to an action of the protection of the protectio				
	February 13, 2023.	and Treatment Plan was dated R8's service plan indicated es including reminder for				

Minnesota Department of Health

STATE FORM 6899 Y97113 If continuation sheet 3 of 4

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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KSMS OUR HOUSE LLC			ST NW MN 55912			
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{01640}	eyeglasses/use of vidressing/grooming toileting, bathing, wide compassionate tour meals, housekeeping service plan did not checks.  On April 5, 2023, at (RN)-C verified the assessments were Assessment, Care February 13, 2023, blood glucose checkers.  The licensee's MN dated revised June residents/tenants have	walker, fall risk monitoring, reminders, assist with ellness monitoring, ch, medication management, ng and orientation. R8's include PRN blood glucose as: 3:18 p.m. registered nurse residents service plan and integrated into R8's MN and Treatment Plan dated and stated the treatment of k PRN was not included.  Service Plan Content Policy 2020, indicated all ave an up-to-date service plan to be provided based on the RN.	{01640}			

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Protecting, Maintaining and Improving the Health of All Minnesotans

#### NOTICE OF REMOVAL OF CONDITIONAL LICENSE

**Electronic Delivery** 

February 2, 2023

Licensee KSMS Our House, LLC 204 14th Street Northwest Austin, MN 55912

RE: Conditional License Number 408631

Health Facility Identification Number (HFID) 30630

Project Number(s) SL30630015

### Dear Licensee:

On January 11, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed September 12, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 11, 2023.

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the September 12, 2022 evaluation.

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

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = \$500 0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = \$500 1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) = \$500 2110-Policies-144g.82 Subd. 3 = \$500

The details of the violations noted at the time of this follow-up evaluation completed on January 11, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the total amount you are assessed is \$2,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 11, 2023, we identified the following violation(s):

KSMS Our House LLC February 2, 2023 Page 2

0900-Contract Required-144g.50 Subdivision 1 1700-Provision Of Medication Management Services-144g.71 Subd. 2

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

### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

## **IMPOSITION OF FINES:**

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

### **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Please <a href="mailto:emailto:

Please address your cover letter for general reconsideration requests to:

Reconsideration Unit

Health Regulation Division

Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit

Health Regulation Division

KSMS Our House LLC February 2, 2023 Page 3

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

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

## **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jodi Johnson at 507-344-2730.

Sincerely,

Maria King, RN **Division Director** 

Naria King

Minnesota Department of Health Health Regulation Division

PMB

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		R <b>01/11/2023</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
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	In accordance with 144G.08 to 144G.9 been issued pursual Determination of what corrected requires or requirements provide indicated below. What contains several ite of the items will be compliance.  INITIAL COMMENT Project SL3063001  On January 9, 2023 the Minnesota Department of the above orders issued pursual September 9, 2022 there were 14 resid the Assisted Living	PROVIDER LICENSING DER  Minnesota Statutes, section 5 this correction order(s) has ant to a survey.  Mether a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of  TS:  S, through January 11, 2023, artment of Health conducted a provider to follow-up on uant to a survey completed on . At the time of the survey, ents receiving services under with Dementia Care license. evisit, the following orders were		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assit tag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding textate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEADTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TREDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.  The letter in the left column is used tracking purposes and reflects the and level issued pursuant to 144G subd. 1, 2, and 3.	oftware. to sted signed column Statute ct of the listed in encies" s the le state This as eyors' rection. DING OF THIS ON FOR TATE d for scope	
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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KSWS U	UR HOUSE LLC	AUSTIN,	MN 55912			
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{U 020}	for reporting maltre abuse prevention p (a) The assisted livid the requirements for maltreatment of vul 626.557. The facilit implement a writter cases of suspected.  This MN Requirements by: Based on interview licensee failed to im Minnesota Adult Ab	atment of vulnerable adults; lan. ing facility must comply with	(0 020)			
	violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number situation has occurr found to be pervasional to be pervasional to the findings included the find	e: d immediate report to MAARC physical and verbal abuse. uded dementia. t identified estimated date of				
	incidence was Nove	ember 8, 2022. A description ated an unlicensed personnel				

Minnesota Department of Health

STATE FORM 6899 Y97112 If continuation sheet 2 of 66

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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{0 620}	(ULP) reported she into her wheelchair to "shut up". R9 was ULP also stated she shut up during one no other witnesses was suspended that here."  The MAARC Form Submitted was Tue 3:59 p.m. (seven do occurred on Novem R1 R1's diagnoses incles R1's diagnoses incles was reported incidence was Not description of the inwanting more cofferminute and then tol would get some in a statement provided is seeing this report Assistant director his chedule while she [ULP-J] no longer was the last time should provide the statement provided in seeing this report Assistant director his chedule while she [ULP-J] no longer was the last time should provide the statement provided in seeing this report Assistant director his chedule while she [ULP-J] no longer was the last time should prove the statement provided in seeing this report Assistant director his chedule while she [ULP-J] no longer was the last time should prove the statement provided in the statement provided in seeing this report Assistant director his chedule while she [ULP-J] no longer was the last time should prove the statement provided in the state	saw ULP-J forcing R9 back by her shoulders and told R9 is not able to confirm or deny. It heard ULP-J telling R9 to of her behaviors. There were "This staff member [ULP-J] to day and no longer works identified Date/Time stay November 15, 2022, at any after date of incidence of the stay of the	,			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	AUSTIN, N	MN 55912			
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them to shut up. W food she either ignor cannot have anymore resident care assist second note reads: residents. I heard hasked for more coffup during one of he standing up I saw [ishoulders and force wheelchair. This was by RCA [ULP-L]." The further indicated on [vulnerable adult] results of the state incidences above incidences above incidences above investigation notes. We was off a few days should of been filed investigation notes stated the former lie (LALD-A) said to with MAARC report). Results and informed staff in the licensee's Repundicated team mer witnessed question communication (veresident/tenant, can visitor, or non-care suspicions to the distaff immediately a if they have all the formation in the staff immediately a if they have all the staff immediately a if the st	s at [R1] and [R9] and tells hen the residents ask for more bres them or tells them they bre." "This note was written by tant (RCA) [ULP-K]." "The [ULP-J] is very rude to the er tell [R1] to shut up when he fee. She also told [R9] to shut or behaviors. When [R9] was ULP-J] grab [R9] by the endown into her as also dated 11/8/22 written he Investigation Summary November 15, 2022, "VA export was completed."  2, at 2:01 p.m. registered d, "We became aware" of the pon November 9". "Staff left had to do an investigation. I between. I realized they it days ago. I waited until came back to us." RN-C censed assisted living director ait with reporting (filing a N-C stated we educated staff	{0 620}			

Minnesota Department of Health

STATE FORM 6899 Y97112 If continuation sheet 4 of 66

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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{0 620}	reporting immediate the director or assis any unexplained inj reporter has reasor adult has sustained reasonably explaine No further informati	ely, regardless of the facts, by stant director to the MAARC uries, which are defines as if a to believe that the vulnerable an injury which is not ed.  on was provided.	{0 620}			
{0 660} SS=F	(a) The facility must comprehensive tuber program according tuberculosis infection the United States C and Prevention (CE Elimination, as publicated and Mortality Week include a tuberculosic covers all paid and contractors, student volunteers. The cortechnical assistance the guidelines.  (b) The facility must compliance with this This MN Requirement by:  Based on interview licensee failed to est (tuberculosis) prevents as the centers for Diseased on the most the centers for Diseased on the Center for Diseased On	en control guidelines issued by enters for Disease Control (C), Division of Tuberculosis ished in the CDC's Morbidity by Report. The program must sis infection control plan that unpaid employees, its, and regularly scheduled enmissioner shall provide e regarding implementation of its maintain written evidence of its subdivision.  The transfer of th	{0 660}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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violation that did resident's health or cause serious injustions are perfailure that has af a large portion or the findings inclusion. The licensee's TE November 11, 20 low risk.  TB POLICY The licensee's Mit Policy dated Decadministrative rescontrol program: responsible for eat TB prevention and Responsibilities in living staff and coapplicable regard infection control producted and the did not include the transmission.  TB PLAN/EDUCATHE INCOME.	alted in a level two violation (a not harm a resident's health or e potential to have harmed a or safety, but was not likely to ary, impairment, or death), and ridespread scope (when wasive or represent a systemic fected or has potential to affect all of the residents).  de:  a facility risk assessment dated 22, indicated the licensee was a nested and a factor of the residents					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30630	B. WING		l l	R <b>11/2023</b>
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NAME OF	PROVIDER OR SUPPLIER	204 14Th		STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC AUSTIN,					
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORR	ECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{0 660}	Continued From pa	ge 6	{0 660}			
	actions will be taken include assistance of the resident to an collaborating and copublic health and M or confirmed TB is addressed, identify the plan or do addit be promptly address.  The licensee lacked plan for the procedure ferral according to isolation and referra	n immediately, which may with arrangement for transfer inpatient facility while coperating with local and DH. 9, If a case of suspected not promptly recognized and why and take steps to change ional training to assure it will ses in the future."  If a written TB infection control ares to address isolation and of MDH guidelines as below for al; therefore, none of the ses had received training on				
	assisted living direct licensee's TB policy	2, at 2:12 p.m. licensed tor (LALD)-B reviewed the and stated "okay" regarding a lacked procedures to and referral.				
	Settings" dated July guidelines, indicated Minnesota should he control program that infection control production. To five for all HCWs should be appropriated and educational or the HCW. In medius should be conducted should annually evalund conduct training focus on basic information.	ol in Minnesota Health Care v 2013, and based on CDC d all health care settings in lave an up-to-date TB infection at included: Written TB ocedures; Health care worker TB training is required at time at to the job responsibilities professional background of m-risk settings, TB training and annually. Low-risk settings aluate the need for TB training, g as needed. Content should				

Minnesota Department of Health

STATE FORM 6899 Y97112 If continuation sheet 7 of 66

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		_	,
		30630	B. WING		01/1	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
		AUSTIN, I	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 660}	care setting 's infection implement your ear referral procedure), employees are responded in the set of the se	TB disease, and Your health ction control plan (i.e., how to bly recognition, isolation, and especially any sections that consible for implementing. A program should include the infection control procedures. address: Early recognition: All is should know the signs and id their role in their facility's TB orgam. Isolation: Place a is TB patient in an airborne and the room with door shut. It ing does not handle TB otentially infections TB patients equipped to evaluate and treat	{0 660}			
{0 730} SS=E	Contents of a reside following for each re (1) identifying informame, date of birth, number; (2) the name, address the resident's emer representatives, an (3) names, address the resident's health providers, if known; (4) health informatic allergies, and when medications, treatments are contents of the resident's health providers, if known; (4) health informatic allergies, and when medications, treatments are contents of the resident services and the residents of the residents o	nation, including the resident's address, and telephone ess, and telephone number of gency contact, legal designated representative; es, and telephone numbers of and medical service	{0 730}			

Minneso	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R 01/11/2023	
		30630	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KeMe O	UR HOUSE LLC	204 14TH				
KSWIS O	OK HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{0 730}	Continued From pa	ge 8	{0 730}			
	(6) copies of any he guardianships, pow conservatorships; (7) the facility's curr assessments and s (8) all records of co resident's services; (9) documentation or resident's status and the needs of the resident appropriate supprofessional; (10) documentation resident and actions needs of the reside appropriate superviprofessional; (11) documentation provided as identified (12) documentation and reviewed the as (13) documentation any resolution; (14) a discharge superviprofessional; (15) other documentation and reviewed the as (13) documentation any resolution; (14) a discharge superviprofessional; (15) other documentation and reviewed the as (15) other documentation and relevantation and relevantation and relevantation.	rent and previous rervice plans; rmmunications pertinent to the of significant changes in the rd actions taken in response to resident, including reporting to rervisor or health care of incidents involving the restaken in response to the rnt, including reporting to the sor or health care that services have been red in the service plan; rethat the resident has received resisted living bill of rights; reformed for complaints received and remary, including service reand related documentation, red retail to the resident's services or				
	by: Based on observati review, the licensee registered nurse (R assessments of res	on, interview, and record e failed to ensure the N) had documented sidents related to change in hree residents (R1, R2, R8).				

STATE FORM 6899 Y97112 If continuation sheet 9 of 66

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		30630	B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN. I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 730}	This practice result violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited numb situation has occurrifound to be pervasi.  The findings include R1 R1 diagnoses incluintellectual disability obstructive pulmona (high blood pressur R1's Service Plan, assessment, was diservice plan indicate including medication checks, dressing/grands showers/skin care, alcohol/tobacco sup On January 9, 2023 personnel (ULP)-E blood sugar.  R1's Concern report indicated R1 called spot on his back. No complaining about a neck.	ed in a level two violation (a st harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and stern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).  e:  ded type 2 diabetes, mild y, heart failure, chronic ary disease and hypertension re).  integrated into R1's lated November 30, 2022. R1's led R1 received services in management, blood sugar rooming reminders, assist with behavior management, and	{0 730}			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		30630	B. WING		01/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
{0 730}	Continued From pa	ge 10	{0 730}			
	registered nurse (R	documented evidence a N) followed up on the concern sment was conducted by an				
	she had "talked to [ RN-C stated, "Ther stated regarding do	23, at 1:35 p.m. RN-C stated R1]" and looked at R1's neck. e was nothing there". RN-C cumentation of follow up for s record,"I don't see it. I know				
	R2 R2's diagnoses included dementia and repeated falls.					
	R2's Service Plan, integrated into R2's assessment, was dated November 16, 2022. R2's service plan indicated R2 received services including assist with hearing aids/eyeglasses, assist with transfers, fall risk monitoring, supervision for safety, evacuation assist, assist with dressing/grooming/toileting/bathing, wellness monitoring, compassionate touch, skin care, eating assistance, environmental assistance, housekeeping, wandering/elopement supervision, assist with anxiety/depression/insomnia, orientation, toe guard use to both big toes, medication management and activity participation.					
		23, at 8:37 a.m. ULP-F was ster medications to R2.				
	has an unusual smo	ed the following: 2, Observation note resident ell pertaining to her vaginal Concern regarding resident				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		30630	B. WING			1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 730}	-November 10, 202 resident report indices smell pertaining to Urine appeared cleen -November 10, 202 documented by RN noted during morning symptoms notes. Provided the resident symptoms notes are completed by an RI to her vaginal area.  On January 11, 202 she had "looked at "urine collected. I de [R2] had no concered by an RI to her vaginal area.  On January 11, 202 she had "looked at "urine collected. I de [R2] had no concered by an RI to her vaginal area. The resident squirted blooked at "urine collected. I de [R2] had no concered by the rectum are sident squirted blooked at it and if bleeding back or if resident she wat it and if bleeding back or if resident she comber 22, 202 regarding resident she comber 22, 202 regarding resident update to RN-C, in times whe problematic use as -December 22, 202 a.m. documented be hemorrhoids are problemated by the rectument of the rectume	22, concern regarding a cated resident has a unusual her vaginal area and her urine. ar and light yellow in color. 22, Observation note -C, indicate no vaginal odor ng cares. No fever, no UTI rimary was notified via phone. documented evidence a sessment of R2 was N for unusual smell pertaining and her urine.  23, at 2:46 p.m. RN-C stated [R2]". RN-C stated she had id not think was abnormal. Inside the next few days."  24, Observation note at 2:45 resident, when I was assisting area I noticed blood, then cood from rectum onto toilet. I called nurse (RN-C) and be in, in the a.m. to look continued severely to call experienced any pain. 22, Observation note concern has been filled out. 22, Concern Regarding a concern documented by	{0 730}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SLIB//EV
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	30630	B. WING		1	1/2023
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PROVIDER OR SUPPLIER			STATE, ZIP CODE		
UR HOUSE LLC		_			
SI IMMADV STA			DDO//IDED'S DI AN DE CODDECTIO	)N	(VE)
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 12	{0 730}			
RN-C for bleeding f	rom rectum.				
she had "told staff of hemorrhoids. I aske actually that much I physically. It was a	over the phone probably ed how much blood. Not blood. I did check over [R2] flare up of hemorrhoids."				
R8 R8's diagnoses included dementia.					
R8's Service Plan, integrated into R8's assessment, was dated November 3, 2022. R8's service plan indicated R8 received services including reminder for eyeglasses/use of walker, fall risk monitoring, evacuation assist, reminders for dressing, reminders/set-up assist for grooming, assist with toileting/bathing, wellness monitoring, compassionate touch, medication management, meals, housekeeping and orientation.					
-November 17, 202 regarding resident If -November 17, 202 lower back pain ind resident room to give mentioned that her Resident stated that pain on a scale of 1 moved, her pain on -November 18, 202 documented by RN resident had complication of the scale of 1 moved in th	2, Observation note, concern nas been filled out. 2, Concern regarding resident icated when staff went into we R8 medication, R8 lower back was hurting. It when she was laying still her -10 was a 5 and when she a scale of 1-10 was a 10. 2, Observation note -C, indicated last night aints of back pain. Resident of the complaints after getting (used to treat pain).				
	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa RN-C for bleeding f  On January 11, 202 she had "told staff of hemorrhoids. I aske actually that much I physically. It was a RN-C stated, "I just  R8 R8's diagnoses incl  R8's Service Plan, assessment, was d service plan indicat including reminder fall risk monitoring, for dressing, remind grooming, assist wi monitoring, compas management, meal orientation.  R8's record identific -November 17, 202 regarding resident I -November 17, 202 lower back pain ind resident room to give mentioned that her Resident stated that pain on a scale of 1 moved, her pain on -November 18, 202 documented by RN resident had compl did not have any fur as needed Tylenol (e)	ATT OF DEFICIENCIES TO F CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  30630  PROVIDER OR SUPPLIER  UR HOUSE LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  RN-C for bleeding from rectum.  On January 11, 2023, at 2:46 p.m. RN-C stated she had "told staff over the phone probably hemorrhoids. I asked how much blood. Not actually that much blood. I did check over [R2] physically. It was a flare up of hemorrhoids." RN-C stated, "I just need better documentation".  R8  R8's diagnoses included dementia.  R8's Service Plan, integrated into R8's assessment, was dated November 3, 2022. R8's service plan indicated R8 received services including reminder for eyeglasses/use of walker, fall risk monitoring, evacuation assist, reminders for dressing, reminders/set-up assist for grooming, assist with toileting/bathing, wellness monitoring, compassionate touch, medication management, meals, housekeeping and orientation.  R8's record identified the following: -November 17, 2022, Observation note, concern regarding resident has been filled out.	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER (X2) MULTIPL A. BUILDING:  30630  B. WING	INTOE DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER  30630  STREET ADDRESS, CITY, STATE, ZIP CODE 204 14TH ST NW AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  RN-C for bleeding from rectum.  On January 11, 2023, at 2.46 p.m. RN-C stated she had "told staff over the phone probably hemorrhoids." as a flare up of hemorrhoids."  RN-C stated, "I just need better documentation".  R8 R8's Gaiganoses included dementia.  R8's Service Plan, integrated into R8's assessment, was dated November 3, 2022. R8's service plan indicated R8 received services including reminder for eyeglasses/use of walker, fall risk monitoring, evacuation assist, reminders for dressing, reminders/set-up assist for grooming, assist with tolleting/bathing, wellness monitoring, compassionate touch, medication management, meals, housekeeping and orientation.  R8's record identified the following: -November 17, 2022, Observation note, concern regarding resident has been filled outNovember 17, 2022, Concern regarding resident lower back pain indicated R8 medication, R8 mentioned that her lower back was hurting. Resident stated that when she was laying still her pain on a scale of 1-10 was a 5 and when she moved, her pain on a scale of 1-10 was a 5 and when she moved, her pain on a scale of 1-10 was a 10November 18, 2022, Observation note documented by RN-C, indicated last night resident to complaints of back pain. Resident did not have any further complaints after getting as needed Tylenol (used to treat pain).	IX1) PROVIDER INFLIGATION NUMBER:  30630  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912  REQUIRED SUMMARY STATEMENT OF DEFICIENCIES (EACH CORNECTION OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REQUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MILST BE PRECEDED BY FILL REGUIRED OF A BUILDING:  [EACH CEPTICENCY MIL

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R		
		30630	B. WING			1/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS OUR HOUSE LLC 204 14TH AUSTIN,			ST NW MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{0 730}	Continued From pa	ge 13	{0 730}				
	physical assessme back pain.	nt by an RN for follow up of					
	regarding assessm pain, "yeah, I felt at remember about bo provide any sympto	23, at 2:46 p.m. RN-C stated ent of R8 for follow up of back odomen and back. I don't owel check. [R8] did not oms at that time. They gave fylenol. I suppose I could have					
	-November 20, 2022, Observation note indicated this writer noticed R8's butt crack was very red and raw. The staff person applied barrier cream and sprinkled a little Nystatin powder (treats fungal or yeast infections of the skin) onNovember 20, 2022, Concern Regarding a Resident concern form indicated the sameNovember 21, 2022, Observation note documented by RN-C, indicated staff noted redness to peri-area. This is a chronic issue and scheduled Nystatin is effective. No further concerns noted today.						
	-	documented evidence of nt by an RN for follow up of red and raw.					
	R8 had scheduled I RN-C stated, "Whe looked pretty clear has "bowel incontin	23, at 2:46 p.m. RN-C stated Nystatin for skin concerns. n I checked on her that a.m., at that time." RN-C stated R8 ence", which "irritates skin." need better documentation."					
	2022, indicated nur completed by a reg	Initial and Ongoing sidents policy dated December sing assessments were istered nurse based upon the nt schedule and as needed					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		30630	B. WING		01/	11/2023	
	PROVIDER OR SUPPLIER	STREET AI <b>204 14T</b> F		TATE, ZIP CODE			
KSMS O	UR HOUSE LLC		MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{0 730}	based upon resider complete the follow assessments of the and cognitive needs resident condition. A assessments as incircumstances. A coincludes but may no	at condition. A RN would ing comprehensive nursing resident's physical, mental, as as required: 4. Change in An RN would complete dicated by individual resident comprehensive assessment of be limited to the ed by Minnesota rules.	{0 730}				
{0 800} SS=F	physical environme  (4) keep the physic walls, floors, ceiling systems, and equip good repair and ope health, safety, comfresidents in accordarepair program.	cal environment, including, all furnishings, grounds, ment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and ent is not met as evidenced	{0 800}				
0 900 SS=C	(a) An assisted livin provide housing or individual unless it is contract with the result (b) The contract muconcerning the proving housing; (2) assisted living services	ıst contain all the terms	0 900				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		30630	B. WING		01/1	1/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS O	UR HOUSE LLC	204 14TH					
(VA) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	MN 55912	PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
0 900	Continued From pa	ge 15	0 900				
	agreement or other (3) the resident's se	agreement; and ervice plan, if applicable.					
	the Office of Ombuc complete unsigned (2) give a complete and any addendum documents and atta	tive residents and provide to dsman for Long-Term Care a copy of its contract; and copy of any signed contract s, and all supporting achments, to the resident ntract and any addendum has					
	(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.						
	(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.						
	additions or amend agreement betweer a new contract or a	ust agree in writing to any ments to the contract. Upon in the resident and the facility, in addendum to the existing kecuted and signed.					
	by: Based on interview licensee failed to ex	ent is not met as evidenced and record review, the secute a written contract which se of three residents (R1, R2,					
	violation that has no a minimal impact or affect health or safe widespread scope (	ed in a level one violation (a potential to cause more than in the resident and does not ety), and was issued at a (when problems are pervasive emic failure that has affected					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		R <b>01/11/2023</b>	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
KSMS O	UR HOUSE LLC	204 14TH	_			
		AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
0 900	Continued From pa	ge 16	0 900			
	or has potential to a the residents).	affect a large portion or all of				
	The findings include	e:				
	R1's admit date was	s May 3, 2021.				
	R2's admit date was July 27, 2021.					
	R8's admit date was August 4, 2022.					
	R1, R2, and R8's records lacked documented evidence the licensee provided the licensee's revised "Resident and Service Agreement" contract dated December 15, 2022, following the survey concluded on September 12, 2022.					
	On January 9, 2023, at 10:07 a.m. during entrance conference, licensed assisted living director (LALD)-B stated regarding the licensee's contract having required information and the revised contract being provided to residents following survey exited on September 12, 2022, "we have a new one [contract]. Last week was reviewed by the nurse consultant. We are going to be sending out." LALD-B stated the revised licensee's contract was not yet provided to residents following the survey exited on September 12, 2022.					
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
{0 930} SS=C	144G.50 Subd. 2 (d	l-e; 1-4) Contract information	{0 930}			
		st include a description of the esolution process available to				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  (CAL) DI  PREFIX TAG  (PAG) DI  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (PAG) DI  PREFIX TAG  (PAG) DI  REGULATORY OR LISC IDENTIFYING INFORMATION)  PREFIX TAG  (PAG) DI  PREFIX TAG  (PAG) DI  REGULATORY OR LISC IDENTIFYING INFORMATION)  PREFIX TAG  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  (PAG)  DI  PREFIX TAG  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  (PAG)  DATE  (PAG)  DATE  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  DATE  (PAG)  DATE  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  DATE  (PAG)  DATE  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  DATE  (PAG)  DATE  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  DATE  DATE  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  DATE  (PAG)  (PAG)  CROSS-REFERENCED TO THE APPROPRIATE  (PAG)  CROSS-REFE		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW  AUSTIN, MN 55912    CAN   D				7. BOILDING.		R	
CAN   ID   SUMMARY STATEMENT OF DEFICIENCIES   CRACH DEFICIENCY   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CROSS-REFER			30630	B. WING			
XASTIN, MN 55912   XASTIN	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
Canding   Cand	KSMS O	UR HOUSE LLC					
residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.  (e) The contract must include a clear and conspicuous notice of:  (1) the right under section 144G.54 to appeal the termination of an assisted living contract;  (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;  (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;  (4) the resident's right to obtain services from an unaffiliated service provider;  This MN Requirement is not met as evidenced by:  Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R8).  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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
The findings include:  On January 9, 2023, at 10:07 a.m. during	{0 930}	residents, including information of the p who is designated to complaints.  (e) The contract mucconspicuous notice (1) the right under stermination of an as (2) the facility's poliresidents within the circumstances a tracircumstances underequired for a trans (3) contact information ombudsman for Lo Ombudsman for Lo Ombudsman for Lo Ombudsman for Lo Ombudsman for Mo Developmental Distriction (4) the resident's rigunaffiliated service  This MN Requirements by:  Based on interview licensee failed to extend the required content (R1, R2, R8).  This practice result violation that has not a minimal impact of affect health or safe widespread scope (or represent a syste or has potential to a the residents).  The findings include the complete of the system of the system of the residents.	In the name and contact person representing the facility to handle and resolve ast include a clear and a of: Section 144G.54 to appeal the esisted living contract; cy regarding transfer of a facility, under what ansfer may occur, and the er which resident consent is fer; tion for the Office of ong-Term Care, the ental Health and abilities, and the Office of aplaints; ght to obtain services from an provider; ent is not met as evidenced and record review, the secute a written contract with at for three of three residents ed in a level one violation (a potential to cause more than an the resident and does not ety), and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of etc.	{0 930}			

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		F	,	
		30630	B. WING		1	1/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS O	KSMS OUR HOUSE LLC 204 14T AUSTIN						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{0 930}	director (LALD)-B s contract having req and contact informa representing the fact handle and resolve one [contract]. Last nurse consultant. Wout." LALD-B stated contract was not presurvey exited on Setime, the evaluator licensee's revised of the licensee's contact provided by L. "Designated persor complaints: see apparended form times be communicated to "C. Complaint Resolution for all resident chooses fact of the community is any complaints are and timely manner policy for all resident resident chooses fact of express any convoice concerns inclusively for all resident chooses fact of expressent and/or representative or lepresent verbally or director, complaint Appendix 5 to Residuated December 25 contact information and resolve complaints.	tee, licensed assisted living tated regarding the licensee's uired information of the name ation of the person cility who is designated to complaints, "we have a new week was reviewed by the Ve are going to be sending at the revised licensee's ovided to residents, following eptember 12, 2022. At that requested a copy of the	{0 930}				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		30630	B. WING		01/1	1/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)	
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE	
{0 930}	Continued From pa	ge 19	{0 930}				
	person on-site to ha as indicated on pag not include the nam	information of the designated andle and resolve complaints le 2. of the contract and did le and contact information of for as indicated on page 12. of					
	R1's admit date wa	s May 3, 2021.					
	R2's admit date wa	s July 27, 2021.					
	R8's admit date wa	s August 4, 2022.					
	evidence the licens revised "Resident a contract dated Dec	cords lacked documented ee provided the licensee's and Service Agreement" ember 15, 2022, following the n September 12, 2022.					
	reviewed the licens contract did not incl	22, at 10:10 a.m. LALD-B ee's contract and verified the lude the name and contact utive director as indicated on tract.					
	No further informati	on was provided.					
{01620} SS=E	144G.70 Subd. 2 (cassessments, and i		{01620}				
	be conducted no mafter initiation of sel reassessment and as needed based or esident and canno from the last date of (d) For residents or	essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted in changes in the needs of the texceed 90 calendar days of the assessment.  The process of the text of the assessment of					

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Minnesota Department of Health

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	>
		30630	B. WING		1	1/2023
		00000			<u>  U1/1</u>	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KCMC O	UD HOUSE LLO	204 14TH	ST NW			
KSINIS O	UR HOUSE LLC	AUSTIN, M	/N 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEI IGIENGT)		
{01620}	Continued From pa	ge 20	{01620}			
	9, clauses (1) to (5)	), the facility shall complete an				
		review of the resident's needs				
	and preferences. T	he initial review must be				
	completed within 30	0 calendar days of the start of				
	services. Resident	monitoring and review must				
	be conducted as ne	eeded based on changes in				
	the needs of the res	sident and cannot exceed 90				
		the date of the last review.				
		nform the prospective resident				
		and contact information for				
		sultation services under				
		prior to the date on which a				
		nt executes a contract with a				
		on which a prospective				
	resident moves in, whichever is earlier.					
	This MN Requireme	ent is not met as evidenced				
	by:					
		ion, interview, and record				
		e failed to ensure the				
		(N) had completed a				
	•	ssessment for change in				
		three residents (R2, R8)				
		visit and change in status and				
		RN completed accurate				
		e of three residents (R8).				
		( - /				
	This practice result	ed in a level two violation (a				
		ot harm a resident's health or				
	safety but had the p	potential to have harmed a				
		safety, but was not likely to				
		y, impairment, or death) and				
		ttern scope (when more than a				
		esidents are affected, more				[
		per of staff are involved, or the				[
		red repeatedly; but is not				[
	found to be pervasi	•				
	·	ŕ				
	The findings include	e:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			R
		30630	B. WING			11/2023
NAME OF PROVIDER OR SI	JPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LI	.c	204 14TH	ST NW MN 55912			
OVA) ID SUMM	MADV CT			PROVIDER'S PLAN OF CORRE	CTION	(VF)
PREFIX (EACH DE	FICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{01620} Continued F	rom pa	age 21	{01620}			
R2 R2's diagno falls.	R2 R2's diagnoses included dementia and repeated					
assessment service plant including as assist with the supervision with dressin monitoring, eating assist housekeepit assist with a orientation, medication in participation.  On January observed to  R2's record -December been filled of -December Form indication the response of in this column of "review signessence of conditions a causing dizz -December update to far	R2 R2's diagnoses included dementia and repeated					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
	30630		B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
Kewe O	UD HOUSE LLC	204 14TH	ST NW			
KSIVIS U	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01620}	Continued From pa	ge 22	{01620}			
	related to fall. Staff check on resident von the couch, Resident von the couch, Resident von the couch, Resident von the couch, Resident von the couch assessment as indictional line of the condition, assess assess conditions of the couch volume o	education done to frequently when she is in the living room dent enjoys that area. ot always communicate when back in her wheelchair.  documented evidence of cated on R2's Post fall for "review status of medical or presence of orthostatic s conditions affecting balance, causing dizziness/vertigo" by a easy, at 2:46 p.m. RN-C Fall Investigation Form and completed an assessment of the form and she had no ion regarding the response of dent have medical conditions				
	event report has be -December 29, 202 Form indicated for conditions that may response of "Yes" a in this column must of "review status of presence of orthost conditions affecting causing dizziness/v painful urination" was -January 4, 2023, For fall documented December 29, 2022 resident was sitting the front of wheelch	2, Observation notes resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		30630	B. WING		01/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01620}	Continued From pa	ge 23	{01620}			
	wheelchair.					
	assessment as indi Investigation Form condition, assess for hypotension, assess assess conditions of RN and lacked documentary monitoring and follous painful urination".  On January 11, 202 reviewed R2's Post stated she had not R2 as indicated on further documentat "yes" to "Does resid that may contribute were to encourage	documented evidence of cated on R2's Post fall for "review status of medical or presence of orthostatic is conditions affecting balance, causing dizziness/vertigo" by a umented evidence of ow up for "complaining of 23, at 2:46 p.m. RN-C is Fall Investigation Form and completed an assessment of the form and she had no ion regarding the response of dent have medical conditions to falls". RN-C stated staff R2 to drink fluids, but there tion of nursing intervention in				
	regarding resident I -January 1, 2023, C Bladder Infection/U has cloudy light yell and burning when u vaginal areaJanuary 5, 2023, o by RN-C indicated i ordered to be given R2's record lacked	Observation notes concern has been filled out. Concern Regarding a Resident TI report indicated resident low urine, complaint of stinging urinating and while wiping the observation note documented resident has a UTI. Antibiotic a twice daily for 12 days.  documented evidence of sessment by the RN for				
	change in condition On January 10, 202					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
	30630		B. WING		01/11/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
	018444574074	AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{01620}	Continued From pa	ge 24	{01620}			
	assessment of R2 futl. RN-C stated sidrink fluids, but their nursing intervention.  -January 6, 2023, Roof fall documented fall on January 3, 20 in the front living roof Staff person went for resident in her room complained of right completed range of person checked R2	for change in status related to taff were to encourage R2 to re was no documentation of				
	dinner. Instructions to notify R2's guard with R2. The staff p the guardian said to she complains of airt gets too bad, ther -January 5, 2023, F indicated for "Does conditions that may	given by director on call were lian and see what wants to do berson called the guardian and be keep an eye on R2, see if any pain throughout the night, if a send R2 in to get looked at. Post Fall Investigation Form resident have medical a contribute to falls" with and further indicated "answers				
	of "review status of presence of orthost	t be addressed" with direction medical condition, assess for tatic hypotension, assess balance, assess conditions rertigo".				
	assessment as indi Investigation Form condition, assess for hypotension, assess assess conditions of an RN and lacked of comprehensive ass	documented evidence of cated on R2's Post fall for "review status of medical or presence of orthostatic s conditions affecting balance, causing dizziness/vertigo" by documented evidence of sessment by the RN for a related to the fall (complaints				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLI	
						R
		30630	B. WING 01/11		11/2023	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	1 ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{01620}	Continued From pa	nge 25	{01620}			
	of hip pain) and implementation of an intervention.					
	she did not comple assessment of R2	23, at 10:10 a.m. RN-C stated te a comprehensive for change in status related to be do anything" regarding an intervention.				
	On January 11, 2023, at 2:46 p.m. RN-C reviewed R2's Post Fall Investigation Form and stated she had not completed an assessment of R2 as indicated on the form and she had no further documentation regarding the response of "yes" to "Does resident have medical conditions that may contribute to falls".					
	R8 R8's diagnoses included dementia.					
	R8's Service Plan, integrated into R8's assessment, was dated November 3, 2022. R8's service plan indicated R8 received services including reminder for eyeglasses/use of walker, fall risk monitoring, evacuation assist, reminders for dressing, reminders/set-up assist for grooming, assist with toileting/bathing, wellness monitoring, compassionate touch, medication management, meals, housekeeping and orientation.					
	R8's record identified the following: -November 23, 2022, Observation note indicated resident fell on right side between wall and toilet, complained of severe back pain. Called on call, was instructed to call 911. Resident was taken to hospitalAfter Visit Summary dated November 23, 2022, (from hospital) indicated "we didn't find any injuries from your fall today. You should take					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		01/1	₹ 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
Vewe o	UD HOUSE LL C	204 14TH				
KSIVIS U	UR HOUSE LLC	AUSTIN, N	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01620}	Continued From pa	ige 26	{01620}			
	course of antibiotics bladder infection." Similligrams (mg) one before breakfast an -November 23, 202 documented by RN emergency room the injuries found from UTI. CT scan show repeat CT scan show repeat CT scan show resident fell at 5:40 Resident found on toilet, complained of to hospital.  -November 23, 202 indicated for "Does conditions that may response of "Yes" at in this column must of "review status of presence of orthost conditions affecting causing dizziness/v R8's record lacked assessment as indi Investigation Form condition, assess for hypotension, assess as conditions of an RN and lacked of comprehensive asses change in condition implementation of a ACCURATE ASSES	s for 5 days for a possible Start cefdinir (antibiotic) 300 e capsule two times a day and dinner for 5 days. 22, Observation note I-C, indicated resident seen in his morning post fall. No fall. Started on antibiotics for wed thickening of bladder and a buld be done in a few weeks. 22, Resident Event Report mented by RN-C, indicated a.m. in residents bathroom. right side between wall and of severe back pain. Was taken 23, Post Fall Investigation Form a resident have medical y contribute to falls" with and further indicated "answers to be addressed" with direction and the medical condition, assess for tatic hypotension, assess to balance, assess conditions wertigo".  documented evidence of icated on R8's Post fall for "review status of medical or presence of orthostatic as conditions affecting balance, causing dizziness/vertigo" by documented evidence of sessment by the RN for a related to the fall/ER visit and an intervention.				

Minnesota Department of Health STATE FORM

January 2023, identified staff were completing for

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		30630	B. WING			1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH Austin	ST NW MN 55912			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
{01620}	Continued From pa	ge 27	{01620}			
	R8 "blood glucose readings, take blood glucose every a.m. before breakfast."					
		November 3, 2022, did not se check under wellness				
	RN-C verified R8 real	23, at 2:45 p.m. LALD-B and eceived blood sugar checks the treatment of blood s not included in the				
	On January 11, 2023, at 2:46 p.m. RN-C reviewed R8's record and stated, "No, nursing assessment" was completed. RN-C stated she had instructed staff to help R8 more for intervention after the fall. RN-C stated R8's UTI was "likely cause" of fall as R8 was "not a frequent faller" and has had "no issues since".					
	Resident Fall or Injuminnesota locations notified of all falls, a received, the nurse team member is to actions to be taken complete a thoroug and document the a Director Cares Asse ECP and include an details of any injurie	ergency Management Plan 3) uries undated indicated 3) "In s, the RN is to be immediately and based on information will direct the care that the provide and any immediate . The RN will follow up and the assessment of the resident assessment on the Regional essment Form as well as in my recommendations, specific es noted, and any required egarding the resident."				
	2022, indicated nur	Initial and Ongoing sidents policy dated December sing assessments were istered nurse based upon the				

WIIIIII	ta Department of He	ailli	r			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	2
		30630	B. WING		01/11/2023	
			ı		0171	172020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW			
TOING O	OK HOUGE EEG	AUSTIN, I	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01620}	Continued From pa	ge 28	{01620}			
{01640} SS=E	based upon resider complete the follow assessments of the and cognitive needs resident condition. Assessments as incircumstances. A coincludes but may no requirements outlin.  No further information 144G.70 Subd. 4 (assessments)	ed by Minnesota rules. on was provided. i-e) Service plan,	{01640}			
	that services are fir facility shall finalize (b) The service plar include a signature facility and by the reagreement on the service plan must be resident reassessmallity must provide about changes to the and how to contact Long-Term Care. (c) The facility must services required by (d) The service plar must be entered intincluding notice of a when applicable.	calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting ervices to be provided. The ervices to be provided. The ervised, if needed, based on lent under subdivision 2. The enformation to the resident in facility's fee for services the Office of Ombudsman for a timplement and provide all by the current service plan. In and the revised service plan to the resident record, a change in a resident's fees services must be informed of service plan.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						R	
		30630	B. WING			1/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS OUR HOUSE LLC 204 14TH AUSTIN, N		ST NW MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{01640}	Continued From pa	ge 29	{01640}				
	by: Based on observation review, the licenses plan was revised woof three residents (In this practice result violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number.	ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not					
	The findings include	e:					
		d revision of R1's service plan ervice of as needed (PRN) s.					
	R1's diagnoses including mild intellectual disc	luded type two diabetes and ability.					
	Assessment MN wards R1's service plan in including medication dressing/grooming showers/skin care, alcohol/ tobacco sublood sugar checks	reminders, assist with behavior management, pervision and staff assist with four times daily.					
		3, at 11:02 a.m. unlicensed was observed to check R1's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		30630	B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	I ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01640}	Continued From pa	nge 30	{01640}			
	blood sugar.					
	R1's Medication Administration Record dated January 2023, identified "blood glucose check use to test blood sugar (BS) up to 8 times per day."					
	assisted living direct residents service properties integrated. LALD-B scheduled blood sured and could have blootimes a day. LALD-integrated into R1's November 30, 2022	23, at 2:32 p.m. licensed ctor (LALD)-B verified the lan and assessments were verified R1 was receiving ligar checks four times ad day od sugar checked up to eight B reviewed R1's Service Plants Our House Assessment MN 2, and stated "yeah, it's not in R1's BS checks as needed limes a day.				
		d revision of R8's service plan ervice of blood sugar checks				
	R8's diagnoses inc	luded dementia.				
	Assessment MN was R8's service plan ir including reminder fall risk monitoring, for dressing, reminingrooming, assist will monitoring, compassions.	ntegrated into R8's Our House as dated November 3, 2022. Indicated R8 received services for eyeglasses/use of walker, evacuation assist, reminders ders/set-up assist for ith toileting/bathing, wellness ssionate touch, medication ls, housekeeping and				
	January 2023, iden	Iministration Record dated tified staff were completing for readings, take blood glucose				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 t. BOILBII (6.		R	
		30630	B. WING			1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01640}	Continued From pa	ge 31	{01640}			
	every a.m. before b	reakfast."				
	Assessment MN wa	ntegrated into R8's Our House as dated November 3, 2022, d glucose check under n/Treatment.				
	RN-C verified R8 w service of blood sug R8's Service Plan ir Assessment MN da	23, at 2:45 p.m. LALD-B and as receiving the treatment gar checks. LALD-A reviewed ntegrated into R8's Our House ted November 3, 2022, and t of blood glucose checks was				
	dated revised June residents/tenants ha	ave an up-to-date service plan to be provided based on the				
	No further informati	on was provided.				
{01650} SS=F	144G.70 Subd. 4 (f) and revisions to	) Service plan, implementation	{01650}			
	the fees for services service, according to assessment and rest (2) the identification who will provide the (3) the schedule and assessments of the (4) the schedule and providing services; (5) a contingency place.	the services to be provided, s, and the frequency of each o the resident's current sident preferences; of staff or categories of staff services; d methods of monitoring resident; d methods of monitoring staff and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPL	E CONSTRUCTION	(X3) DATE	SLIDVEV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			LETED
			A. DUILDING.	<del></del>		
		20020	B. WING		F	
		30630	D. WING		01/1	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC			_			
		AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
{01650}	Continued From pa	ge 32	{01650}			
	facility; (iii) the names and the resident wishes emergency or if the change in the reside identification of and authority to sign for and (iv) the circumstance medical services are consistent with chaldeclarations made chapters.	a method to contact the contact information of persons to have notified in an re is a significant adverse ent's condition, including information as to who has the resident in an emergency; sees in which emergency e not to be summoned oters 145B and 145C, and by the resident under those				
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for two of three residents (R1, 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) 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	e:				
	R1 R1's diagnoses incl mild intellectual disa	uded type two diabetes and ability.				
	R1's Service Plan, i assessment was da	ntegrated into R1's ated November 30, 2022. R1's				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					F	
		30630	B. WING		01/1	1/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS OUR HOUSE LLC		ST NW VIN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01650}	service plan indicate including medication dressing/grooming showers/skin care, alcohol/ tobacco sublood sugar checks plan lacked the treatchecks up to 8 time.  On January 9, 2023 personnel (ULP)-E blood sugar.  R1's Medication Ad January 2023, identuse to test blood suday."  R1's Service Plan Is description of service plan include a contingency plar taken if the schedu provided.  R8 R8's diagnoses inc.  R8's Service Plan, assessment, was description assist, is reminders/set-up at toileting/bathing, we compassionate tour meals, housekeepi	red R1 received services in management, reminders, assist with behavior management, apervision and staff assist with a four times daily. R1's service atment service of blood sugar as per day.  B, at 11:02 a.m. unlicensed was observed to check R1's ministration Record dated tified "blood glucose check agar (BS) up to 8 times per acked the following: ices to be provided (as r checks), the fees for the acked the following: ides to be provided (as r checks), the fees for the led service cannot be led service cannot be led service cannot be service for walker, fall risk monitoring, reminders for dressing, reminders for dressing, sesist for grooming, assist with ellness monitoring, ch, medication management, and orientation. R8's the treatment service of blood	{01650}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		R	
		30630			01/1	1/2023
NAME OF I				STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01650}	Continued From pa	ge 34	{01650}			
	January 2023, iden R8 "blood glucose every a.m. before b R8's Service Plan II description of serv sugar checks daily	ministration Record dated tified staff were completing for readings, take blood glucose breakfast."  acked the following: ices to be provided (blood by the fees for the service; and f staff or categories of staff				
	who will provide the -a contingency plar					
	On January 9, 2023, at 10:07 a.m. during the entrance conference, licensed assisted living director (LALD)-B stated the licensee was "still working on as of Friday with consultant". LALD-B verified the contigency plan had not been updated in residents' service plans, since the previous survey was exited on September 12, 2022.					
	verified the residen assessments were R1 was receiving s four times a day an checked up to eigh	23, at 2:32 p.m. LALD-B ts' service plan and integrated. LALD-B verified cheduled blood sugar checks d could have blood sugar t times a day. LALD-B rice Plan and stated "yeah, it's				
	RN-C verified R8 w service of blood su R8's Service Plan a blood glucose chec	23, at 2:45 p.m. LALD-B and ras receiving the treatment gar checks. LALD-A reviewed and verified the treatment of the was not included.  Service Plan Content Policy				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		30630	B. WING			1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH AUSTIN,			ST NW NN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01650}	identifying services assessment by the would include a des services, including the services, the fe identification of the of team members wand a contingency plan to be taken by resident/tenant, and	ave an up-t-date service plan to be provided based on the RN and the service plan scription of the home care treatments, the frequency of es for the service, team members or categories who would provide the service plan that included the action our agency, the d/or responsible party if the cannot be provided.	{01650}			
01700 SS=D	144G.71 Subd. 2 P management service	rovision of medication ces	01700			
	management service providing medication a registered nurse, or authorized presoconduct an assession medication manage provided and how to This assessment mount with the resident. To an identification must in medications, side eallergic or adverse address these issue (b) The assessment medication of medications of medications.	nt who requests medication ces, the facility shall, prior to on management services, have licensed health professional, criber under section 151.37 ment to determine what ement services will be he services will be provided. The nust be conducted face-to-face he assessment must include do review of all medications the conducted be taking. The review and include indications for effects, contraindications, reactions, and actions to es.  In the must identify interventions ment of medications to prevent ation by the resident or others ess to the medications and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING			R <b>11/2023</b>
NAME OF PR	OVIDER OR SUPPLIER			TATE, ZIP CODE		
KSMS OUF	R HOUSE LLC	204 14TH AUSTIN,	SI NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
pd nd stin TbE linn r Tv s r c vii a s T F d F a ti a t n F n	designated represe manage the resider diversion of medica section, "diversion of heft, or illegal or immedications.  This MN Requirement of the section of the medications.  This MN Requirement of the section of the s	to the resident and legal or natives on interventions to natives on interventions to native medications and prevent tions. For purposes of this of medication" means misuse, aproper disposition of the medication	01700			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		30630	B. WING		F 01/1	₹ 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
AUSTIN,		MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
01700	Continued From pa	ge 37	01700			
	name, dosage, route effects, contraindica interventions, and a necessary intervent dosage, route, frequent adverse reaction verified by pharmach new order. Primary and facility is also need medications are storal administered puideline/recomme allergies: anesthesi bacitracin. Medication potential for medication administer room/med cart keys passer to med passare double locked a beginning of every storage, route, frequent adverse reaction R8's record lacked review for "Contrain"	te, frequency, diagnosis, side ations and necessary adverse reactions and tions. See Med list name, uency, diagnosis, side effects, ons. Contraindication is by on admission and with every MD is notified by pharmacy otified as appropriate. All ored, refrigerated if indicated er manufacturer andations. List any medication a, codeine, penicillin's, on assessment of the ation diversion and exent diversion. All medications a staff member assigned to tration at a time. Med are exchanged from the med are dead hands and all narcotics and counted at the end and shift.  In on the specifically reference a ed list See Med list name, uency, diagnosis, side effects, ons" on the assessment and documented evidence of adication is verified by				
	review for "Contraindication is verified by pharmacy on admission and with every new order as indicated on the assessment.  R8's medication administration records (MARs) dated November 2022, December 2022, and January 2023, identified the name, dosage, route and frequency for medications being administered by staff to R8. The MARs indicated Allergies: anesthesia, penicillin's, bacitracin. The MARs lacked indications and side effects of all medications listed and adverse reactions as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 50.25		<sub>F</sub>	۲
		30630	B. WING		01/1	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01700	Continued From pa	nge 38	01700			
	indicated on the as	sessment.				
	were administering preventive for hear for diabetes, one so hypothyroidism, on blood pressure, on used for pain.  R8's record lacked the RN for the follo-documentation the	anuary 2023, indicated staff one medication used as t, one for high cholesterol, one upplement, one used to treat e for constipation, one for high e for skin infections and one a medication assessment by wing required content: e assessment was conducted the resident: and				
	face-to-face with the resident; and -identification of indications and side effects -review of side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.					
	entrance conference director (LALD)-B s that as of Friday. P	3, at 10:07 a.m. during the ce, licensed assisted living stated "we are still developing aper version to use. We ne yet." RN-C stated, "I was yeek."				
	stated the med list assessments was t stated the pharmac contraindications fo the review by the p resident record. LA pharmacist and asl	23, at 12:31 p.m. LALD-B referenced on the the resident's MAR. LALD-B cist completed the reviews for per medications. LALD-B stated harmacist was not part of the LD-B stated she could call the ce for the information.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		01/1	₹ 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01700	the pharmacist was tomorrow to provide contraindications for the licensee's MN Assessment of Res 2022, indicated nurse completed by a regrequired assessment based upon resident complete assessment includes the requirements of the No further information.	a out and would be back the information for review of a medications for R8.  Initial and Ongoing sidents policy dated December sing assessments were istered nurse based upon the nt schedule and as needed at condition. An RN would tents as indicated by individual aces. A comprehensive as but may not be limited to attined by Minnesota rules.	01700			
{01710} SS=E	monitoring and reas  The assisted living reassess the reside services as needed resident presents withat may be medical minimum, annually.  This MN Requirements by:  Based on observation review the licensee reassessment of minimum reasons.	facility must monitor and ent's medication management under subdivision 2 when the vith symptoms or other issues ation-related and, at a ent is not met as evidenced on, interview, and record	{01710}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					F	₹
		30630	B. WING			1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
	OLIMAN AND VIOLA	· ·	MN 55912	PROVIDEDIO DI ANI OF CORDECT		0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01710}	Continued From pa	ge 40	{01710}			
	violation that did no safety but had the p resident's health or cause serious injury was issued at a pat limited number of re than a limited numb	•				
	diagnoses including heart failure, type 2	on date of May 3, 2021, with mild intellectual disability, diabetes, chronic obstructive (constriction of breathing and depression.				
	the service of mediassessment indicat have company continuous medications, compared medications, staff a times per day or less (doctor orders). List prescriptions, over supplements. Including frequency, diagnosis contraindications are and adverse reaction interventions. See Mirequency, diagnosis reactions. Contraindications order. Primary MD is order. Primary MD is seen to see the service of t	November 30, 2022, included cation management. The ed for "Medications" prefers to tracted pharmacy set up any to administer all ssist with medications three is (includes PRN [as needed]) at all medications including the counter medications and de name, dosage, route, is, side effects, and necessary interventions,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. 501251110.	Boilbing.		₹
		30630	B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01710}	medications are stop and administered proguideline/recomme allergies: (nothing with Medication assessing medication diversion. All medications at a staff member assign administration at a are exchanged from passed hands and and counted at the shift.  The assessment dimed list for "See Midosage, route, frequend adverse reactions as indicated on the R1's record lacked review for "Contrain pharmacy on administration and indicated November 20 January 2023, identification frequency and indicated November 20 January 2023, identifications as indicated administered by state Allergies: no known side effects of all midicated frequency and indicated frequen	pred, refrigerated if indicated per manufacturer andations. List any medication was documented in this area). The ment of the potential for on and interventions to prevent cations are locked with one med to medication time. Med room/med cart keys in the med passer to med all narcotics are double locked end and beginning of every.  In the med passer to med all narcotics are double locked end and beginning of every in the assessment and documented evidence of indication is verified by sision and with every new order assessment.  In the mane, dosage, route, cations for medications being aff to R1. The MARs indicated in allergies. The MARs lacked medications listed and adverse ted on the assessment.  In the mane was a session of the medications for syncope in passing out), two for illure, two for sleep, six for COPD, one for depression, ant. one for agitation, two for pain, one for acid reflux and	{01710}			

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REGULATORY OR LSC IDENTIFYING INFORMATION)  RAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  R1's record lacked a medication reassessment by the RN for the following required content: -documentation the assessment was conducted face-to-face with the resident; and -identification of side effects -review of side effects -review of side effects for adverse reactions, and actions to address these issues; and -provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.  R2 R2 had an admission date of July 27, 2021, with diagnoses including dementia and repeated falls.  On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R2.  R2's Service Plan, integrated into R2's assessment indicated for "Medications" prefers to have company contracted pharmacy set up medications, staff assist with medications three times per day or less (includes PRN) (doctor	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CALL   CALL			30630	B. WING			
(X4) D   SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REPIER   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE	KSMS OUR HOUSE LLC			_			
R1's record lacked a medication reassessment by the RN for the following required content: -documentation the assessment was conducted face-to-face with the resident; and -identification of side effects -review of side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.  R2 R2 had an admission date of July 27, 2021, with diagnoses including dementia and repeated falls.  On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R2.  R2's Service Plan, integrated into R2's assessment dated November 16, 2022, included the service of medication management. The assessment indicated for "Medications" prefers to have company contracted pharmacy set up medications, company to administer all medications, staff assist with medications three times per day or less (includes PRN) (doctor	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
by the RN for the following required content: -documentation the assessment was conducted face-to-face with the resident; and -identification of side effects -review of side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.  R2 R2 had an admission date of July 27, 2021, with diagnoses including dementia and repeated falls.  On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R2.  R2's Service Plan, integrated into R2's assessment dated November 16, 2022, included the service of medication management. The assessment indicated for "Medications" prefers to have company contracted pharmacy set up medications, company to administer all medications, staff assist with medications three times per day or less (includes PRN) (doctor	{01710}	Continued From pa	ge 42	{01710}			
orders). List all medications including prescriptions, over the counter medications and supplements. Include name, dosage, route, frequency, diagnosis, side effects, contraindications and necessary interventions, and adverse reactions and necessary interventions. See Med list name, dosage, route, frequency, diagnosis, side effects, and adverse reactions. Contraindication is verified by pharmacy on admission and with every new		by the RN for the for-documentation the face-to-face with the identification of side-review of side effector adverse reaction these issues; and provide instructions designated represe manage the resider diversion of medical R2 R2 had an admission diagnoses including On January 10, 202 personnel (ULP)-Formedications to R2.  R2's Service Plan, if assessment dated If the service of medical the service of medical thave company contimedications, comparedications, staff at times per day or less orders). List all medications are and adverse reaction interventions. See Mirequency, diagnosis reactions. Contraindications.	llowing required content: assessment was conducted e resident; and e effects cts, contraindications, allergic s, and actions to address e to the resident and legal or intatives on interventions to int's medications and prevent tions.  on date of July 27, 2021, with indementia and repeated falls. et a, at 8:37 a.m. unlicensed was observed to administer  integrated into R2's November 16, 2022, included cation management. The ed for "Medications" prefers to racted pharmacy set up any to administer all ssist with medications three es (includes PRN) (doctor dications including the counter medications and de name, dosage, route, s, side effects, and necessary Med list name, dosage, route, s, side effects, and adverse dication is verified by				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R	
		30630	B. WING			1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01710}	Continued From pa	ge 43	{01710}			
	facility is also notifice medications are stop and administered proguideline/recommentallergies: NSAIDs (redrug). Medication at medication diversion. All medication at medication at a staff member assign administration at a staff member assign at a staff member as a staff membe	ndations. List any medication nonsteroidal anti-inflammatory ssessment of the potential for n and interventions to prevent ations are locked with one ned to medication time. Med room/med cart keys n the med passer to med all narcotics are double locked end and beginning of every				
	med list for "See Modosage, route, frequent and adverse reaction R2's record lacked review for "Contrain"	d not specifically reference a sed list See Med list name, uency, diagnosis, side effects, ons" on the assessment and documented evidence of adication is verified by ssion and with every new order assessment.				
	2022, and January dosage, route, frequenciations being a The MARs indicated MARs lacked side 6	November 2022, December 2023, identified the name, uency and indications for administered by staff to R2. d Allergies: NSAIDs. The effects of all medications listed ons as indicated on the				
	were administering gout, four suppleme hypothyroidism, one	nuary 2023, indicated staff one medication used to treat ents, one used to treat e used for sleep, four used for				

Minnesota Department of Health

for sleep, one used for pain, one used to

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Millinesc	ota Department of He	alli				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					l R	2
		30630	B. WING		01/11/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01710}	Continued From pa	ge 44	{01710}			
		three used for dry eyes, one ss, one used for sore throat eat infection.				
	by the RN for the for-documentation the face-to-face with the identification of side review of side effector adverse reaction these issues; and provide instructions designated represe	le effects cts, contraindications, allergic is, and actions to address s to the resident and legal or entatives on interventions to int's medications and prevent				
	entrance conferenc director (LALD)-B s assessment, "we an Friday. Paper version	3, at 10:07 a.m. during the se, licensed assisted living stated regarding medication re still developing that as of on to use. We haven't done stated, "I was going to start				
	stated the med list in assessments was to stated the pharmac contraindications for the review by the pharmac the review by the pharmac the record. LAI	23, at 12:31 p.m. LALD-B referenced on the he resident's MAR. LALD-B sist completed the reviews for medications. LALD-B stated harmacist was not part of the LD-B stated she could call the c for the information.				
	the pharmacist was tomorrow to provide	23, at 2:21 p.m. LALD-B stated sout and would be back the information for review of or medications for R1 and R2.				

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Minnesota Department of Health STATE FORM

The licensee's MN Initial and Ongoing

AND DIANIOE CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30630	B. WING		01/1	≀ 1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
	I	AUSTIN, N	/IN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01710}	Continued From pa	ge 45	{01710}			
{01730} SS=E	2022, indicated nurse completed by a regirequired assessment based upon resident complete assessment esident circumstant assessment include the requirements of the No further information.	idents policy dated December sing assessments were stered nurse based upon the nt schedule and as needed at condition. An RN would ents as indicated by individual ces. A comprehensive es but may not be limited to utlined by Minnesota rules.  on was provided.	{01730}			
	(a) For each resider management service must prepare and ir written statement of services that will be facility must develop individualized mediceach resident based assessment that must (1) a statement des management service (2) a description of on the resident's nediversion, and considirections; (3) documentation or relating to the admit (4) identification of pmonitoring medication refills ar (5) identification of resident services.	nt receiving medication res, the assisted living facility include in the service plan a if the medication management provided to the resident. The coand maintain a current reation management record for d on the resident's rust contain the following: recibing the medication rese that will be provided; restorage of medications based reds and preferences, risk of ristent with the manufacturer's responsible for resident instructions responsible for resident instructions respons responsible for resident management redication management redication management redicated to unlicensed				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
					 	<b>)</b>
		30630	B. WING			1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW			
- KOMO O	OK HOUGE EEG	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE
{01730}	Continued From pa	ge 46	{01730}			
{01730}	(6) procedures for somurse or appropriate when a problem ari management service (7) any resident-specifications that all as prescribed, and to prevent possible reactions. (b) The medication current and updated changes. (c) Medication recowhen a licensed nu professional, or aut medication management with the presidents (R1, R2, IIII). This practice resultation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number.	staff notifying a registered e licensed health professional ses with medication ces; and ecific requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed rse, licensed health horized prescriber is providing ement.  The provided the ensure an cation management plan to content for three of three R8).  The din a level two violation (and tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and there scope (when more than a residents are affected, more per of staff are involved, or the red repeatedly; but is not	{01730}			
	The findings include	e:				
	R1					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		R <b>01/11/2023</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	ST NW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01730}	Continued From pa	ge 47	{01730}			
	R1's Service Plan, i assessment dated R1 received medica	November 30, 2022, indicated				
	dated January 2023 administering two n episode (fainting or congestive heart fa diabetes, three for disorder (COPD), o nasal lubricant. one	ministration Record (MAR) B, indicated staff were nedications for syncope passing out), two for illure, two for sleep, six for chronic obstructive pulmonary ne for depression, two for for agitation, two for pain, one for acid reflux and one for				
	record lacked the for-documentation of second relating to the adminidentification of permonitoring medicated medication refills are identification of medication of medication refills are identification of medication of medication and procedures for state or appropriate licental appropriate licental problem arises with services; and any resident-specifications that all as prescribed, and	medication management bllowing: specific resident instructions nistration of medications; resons responsible for ion supplies and ensuring that re ordered on a timely basis; redication management tasks ted to unlicensed personnel; ff notifying a registered nurse sed health professional when the medication management fic requirements relating to reation administration, medications are administered monitoring of medication use complications or adverse				
	R2's Service Plan, i	November 16, 2022, indicated				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	₹
		30630	B. WING		01/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
0(1) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	MN 55912	DROVIDER'S DLAN OF CORRECTION	ON!	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
{01730}	Continued From pa	ge 48	{01730}			
		23, at 8:37 a.m. unlicensed was observed to administer				
	were administering supplements, one f sleep, four for cons one for pain, one to	nuary 2023, indicated staff one medication for gout, four or hypothyroidism, one for tipation, one for depression, strengthen bones, three for stlessness, one for sore throat ection.				
	record lacked the for-documentation of second relating to the adminidentification of permonitoring medicated medication refills are identification of medication refills are identification of medication and that may be delegated or appropriate licental appropriate licental problem arises with services; and any resident-specifications that all as prescribed, and	medication management bllowing: specific resident instructions nistration of medications; resons responsible for ion supplies and ensuring that re ordered on a timely basis; edication management tasks ted to unlicensed personnel; ff notifying a registered nurse sed health professional when ith medication management fic requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse				
	R8's Service Plan in assessment dated R2 received medical	November 3, 2022, indicated				
	were administering	one medication used as one for high cholesterol, one				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		01/1	R 1/2023
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
KSMS C	UR HOUSE LLC	204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01730}	for diabetes, one so hypothyroidism, one blood pressure, one for pain.  R8's individualized record lacked the form of the adminimation of some particular to the adminimation of the admin	upplement, one for e for constipation, one for high e for skin infections and one medication management ollowing: specific resident instructions nistration of medications; rsons responsible for ion supplies and ensuring that re ordered on a timely basis; edication management tasks ted to unlicensed personnel; ff notifying a registered nurse sed health professional when ith medication management fic requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse  3, at 10:07 a.m. during the ee, licensed assisted living stated the licensee had individualized medication d. Paper version to use. We see yet." RN-C stated, "I was	{01730}			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		01/1	R 1/2023
NAME OF I	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	1 01/1	1/2025
		204 14TH		STATE, ZIF CODE		
KSMS O	UR HOUSE LLC	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01730}	Continued From pa	ge 50	{01730}			
	No further informati	on was provided.				
{01760} SS=D			{01760}			
	living facility staff m resident's record. T include the signatur administered the m must include the me and time administration. The reason why medica completed as presofollow-up procedure the resident's needs administered as prewith the resident's needs administered are sident (R2) who wadministration.	Iministered by the assisted ust be documented in the he documentation must be and title of the person who edication. The documentation edication name, dosage, date red, and method and route of staff must document the tion administration was not exibed and document any best hat were provided to meet as when medication was not escribed and in compliance medication management plan.  The provided to meet as evidenced on, interview, and record a failed to ensure medication is prescribed for one of one was observed for medication.				
	violation that did no safety but had the p resident's health or cause serious injury was issued at an is- limited number of a limited number of	ed in a level two violation (a tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		01/1	₹ 1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		204 14TH				
KSMS O	UR HOUSE LLC	AUSTIN, I	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{01760}	Continued From pa	ige 51	{01760}			
	The findings includ	e:				
	included fiber dissole eight ounces of war eight ounces of war on January 10, 202 personnel (ULP)-F powder medication teaspoon was to be white plastic spoon out of the container into a white paper restopped ULP-F and measure the medicaused a plastic spoor measure." The evaculear plastic medication. ULP-F picked upon. ULP-F picked upon the clear measurements. The medication cup from the clear measurements. The much medication was remaining in the mixed the medication to R2 to On January 10, 202 assisted living direct talked to me. I put of	e evaluator asked ULP-F how vas in the cup and ULP-F aspoon". ULP-F removed ation until one half teaspoon ne medication cup. ULP-F on into the water and gave the ordrink.  23, at 12:00 p.m. licensed ctor (LALD)-B stated, "[ULP-F] on the MAR [medication ord] to use the measuring cup."				
{01940}	144G 72 Subd 3 Ir	ndividualized treatment or	{01940}			
	therapy manageme		(0.0.0)			

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	ta Department of He		1		1	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	,
		30630	B. WING		01/11/2023	
		30030			01/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		204 14TH	ST NW			
KSMS O	UR HOUSE LLC		MN 55912			
	OLIMA A DV OTA	·		DDOVIDEDIO DI ANI OF CODDECTI	ON .	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
(0.4.0.4.0)	0 " 15	50	(0.40.40)			
{01940}	Continued From pa	ge 52	{01940}			
	For each resident re	eceiving management of				
		ed treatments or therapy				
		ed living facility must prepare				
	T					
		ervice plan a written				
		eatment or therapy services				
		to the resident. The facility				
		and maintain a current				
	individualized treatr					
	management record for each resident which must					
	contain at least the	<u> </u>				
		he type of services that will be				
	provided;					
		of specific resident instructions				
	relating to the treatr	ments or therapy				
	administration;					
	(3) identification of	treatment or therapy tasks that				
	will be delegated to	unlicensed personnel;				
	(4) procedures for r	notifying a registered nurse or				
		d health professional when a				
		treatments or therapy				
	services; and	. ,				
	•	ecific requirements relating to				
		eatment and therapy				
		n that all treatment and				
	•	stered as prescribed, and				
		nent or therapy to prevent				
		ons or adverse reactions. The				
	•	y management record must				
		ated when there are any				
	changes.	atoa whom there are any				
	Granges.					
	This MN Doguiron	ant is not mot as avidenced				
	-	ent is not met as evidenced				
	by:	:_+				
		on, interview, and record				
	•	e failed to ensure an				
		nent or therapy management				
		required content for two of				
	three residents (R1	, R8).				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		30630	B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01940}	This practice result violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rothan a limited numb situation has occur found to be pervasional t	ed in a level two violation (a of harm a resident's health or potential to have harmed a safety, but was not likely to by, impairment, or death) and tern scope (when more than a sesidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).  e:  3, at 10:07 a.m. during the se, licensed assisted living stated the licensee's treatment was "in progress."  integrated into R1's November 30, 2022, indicated ent management. The	{01940}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING			R <b>11/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
KSMS C	OUR HOUSE LLC	204 14TH AUSTIN,	I ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{01940}	On January 9, 2023 personnel (ULP)-E blood sugar.  R1's Medication Ad January 2023, identused to test blood sugurose tab immedifor further instruction were recording bloos scheduled times of p.m. and 8:00 p.m.  R1's service pan lact treatment or therap provided to the resinchecks) and lacked treatment and therathe treatment service for the following: -identification of treatment in the delegated to the company of the condition of the sugar checked up to the condition of the sugar checked up to the condition of the condition of the sugar checked up to the condition of the condit	a, at 11:02 a.m. unlicensed was observed to check R1's ministration Record dated diffied blood glucose check ugar (BS) up to 8 times per ugar is 70 or less give one ately then call notify the nurse n. The MAR identified staff od sugar checks for the 7:00 a.m., 11:00 a.m., 5:00 every day.  Cocked a written statement of the y services that would be dent (PRN blood sugar a current individualized apy management record for se of PRN blood sugar checks eatment or therapy tasks that unlicensed personnel.  3, at 2:32 p.m. LALD-B eiving scheduled blood sugar day and could have blood of eight times a day. LALD-B lacked the above for nent record.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING			R 11/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{01940}	management, meal orientation. R8's se the treatment service every day.  R8's Medication Ad January 2023, read blood glucose every R8's service plan lathe treatment or the provided to the resievery a.m.) and lactreatment and therathe treatment service every a.m. for the forcoumentation of selating to the treatment administration; -identification of treatment incomplementation of the residual be delegated to procedures for not appropriate licenses problem arises with services; and any resident-specification that all the treatment or the procedures of a procedure of the residual treatment or the procedure of the residual treatment or the repromplications or adtreatment or the reproductions or additional reproduction	s, housekeeping and rvice plan/assessment lacked be of blood sugar checks ministration Record dated "blood glucose readings, take y a.m. before breakfast."  cked a written statement of trapy services that would be dent (blood sugar checks ked a current individualized apy management record for the of blood sugar checks bllowing: specific resident instructions	{01940}			
	RN-C verified R8 w	23, at 2:45 p.m. LALD-B and as receiving the treatment par checks. LALD-A verified				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30630	B. WING		F	₹ 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{01940}	the treatment of blo included in the serv  The licensee's MN dated revised June residents/tenants had identifying services assessment by the The licensee's Minr Medication Manage Policy dated revised would develop and for each resident/te	od glucose checks was not ice plan.  Service Plan Content Policy 2020, indicated all ave an up-to-date service plan to be provided based on the RN.  nesota Delegation of the ment and Treatment Services di June 2020, indicated the RN individualized treatment plan nant and would develop for treatments that team	{01940}			
{01970} SS=D	There must be an unelectronically record prescriber for all trender order must contain description of the traprovided, and the frameword at least eventual trender or the model of the model. This MN Requirements by:  Based on observation review the licensee	reatment and therapy orders up-to-date written or ded order from an authorized atments and therapies. The the name of the resident, a eatment or therapy to be requency, duration, and other to administer the treatment or and therapy orders must be	{01970}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		30630	B. WING			1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KCMC O	UD HOUSE LL C	204 14TH	ST NW			
KSWS U	UR HOUSE LLC	AUSTIN, N	/IN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01970}	Continued From pa	ge 57	{01970}			
	violation that did no safety but had the p resident's health or cause serious injury was issued at an iso limited number of re a limited number of situation has occurre	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and polated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	The findings include:					
	R1's diagnoses included type two diabetes and mild intellectual disability.					
		November 30, 2022, indicated ent services which included				
		3, at 11:02 a.m. unlicensed was observed to check R1's				
	dated January 2023	ministration Record (MAR) 8, identified "blood glucose ood sugar (BS) up to 8 times				
		d a prescriber's order dated or accu-check guide test strip o 8 times daily.				
	R1's record lacked scheduled BS chec	a prescriber's order for ks four times daily.				
	assisted living direct signed order" in R1	3, at 2:32 p.m. licensed tor (LALD)-B there was "no 's record scheduled BS illy. RN-B stated she "could				

Minnesota Department of Health

STATE FORM 6899 Y97112 If continuation sheet 58 of 66

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		R <b>01/11/2023</b>	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 •	
KSMS O	KSMS OUR HOUSE LLC 204 14TH AUSTIN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01970}	contact [nurse prace] The licensee's Minr Medication Manage Policy dated June 2 required a prescript treatment services the residents. The Fensuring current preprescriber for treatment administered by the	tioner] to make more specific." nesota Delegation of the ment and Treatment Services 1020, indicated the company ion for all medication and team members manage for RN was responsible for escriptions from authorized ments and therapies to be team members and the the resident record.	{01970}			
{02110} SS=F	(a) In addition to the required in the licentassisted living facility must develop and in procedures that add (1) philosophy of he based upon the assisted u	e policies and procedures ising of all facilities, the ty with dementia care licensee implement policies and dress the:  by services are provided isisted living facility licensee's dipromotion of and how the philosophy ed;  havioral symptoms and for intervention plans, lacological practices that are dievidence-informed;  egress prevention that structions to staff in the event agement, including an dents for the use and effects	{02110}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		30630	B. WING		01/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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AUSTIN, N			DDOVIDEDIO DI ANI OF CODDECTIO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{02110}	Continued From pa	ge 59	{02110}			
	how activities are in (7) description of far efforts to keep the far (8) limiting the use intercom systems for evacuation drills on (9) transportation count from outside m (10) safekeeping of (b) The policies and to residents and the designated represe move-in.	mily support programs and family engaged; of public address and or emergencies and ly; coordination and assistance to edical appointments; and fresidents' possessions. It procedures must be provided a residents' legal and intatives at the time of				
	This MN Requirement is not met as evidenced by:  Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care and failed to provide the policies and procedures to residents and the residents' legal and designated representatives at the time of move-in.  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 wides are pervasive or rep has affected or has portion or all of the	pread scope (when problems present a systemic failure that the potential to affect a large residents).				
	The findings include	e:				
		censed as an Assisted Living e facility on August 1, 2022.				

Minneso	Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
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{02110}	Continued From pa	ge 60	{02110}				
	The licensee lacked procedures related - philosophy of how based upon the ass values, mission, an person-centered cabe implemented; - medication managassessment of resign of medications- lack psychotropic medicativities are implereductivities are imple	d the following policies and to dementia care: services are to be provided sisted living facility licensee's d promotion of the and how the philosophy will gement, including an dents for the use and effects as content that includes ations; enrichment programs and how mented; ily support programs and ly engaged; public address and intercomencies and evacuation drills; ordination and assistance to edical appointments; and sidents' possessions  The see's Behavior Monitoring Procedure revised May 2020, the addressed design of nation plans, including					
	entrance conference developed. LALD-B were not provided to	etor (LALD)-B stated during the e dementia policies were stated dementia policies the residents and the designated representatives,					

but were "going to be sent out with new contract

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		30630	B. WING		01/1	1/2023
	PROVIDER OR SUPPLIER  UR HOUSE LLC	204 14TH	ST NW	STATE, ZIP CODE		
	OK 110002 220	AUSTIN, I	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{02110}	Continued From pa	ge 61	{02110}			
(02110)	on the 19th of Janu Friday the 13th sho for dementia were represented the license Record Policy and Fand stated she did which addressed deintervention plans, in practices that are previdence-informed stated she had mor provide them, regar LALD-B stated a policy for demand the provide them.	ary." LALD-B then stated, "By uld be ready to go." Policies requested by the evaluator.  3, at 2:12 p.m. LALD-B ree's Behavior Monitoring Procedure revised May 2020, not see in the policy content resign of supports for including nonpharmacological reson-centered and was addressed. LALD-B redementia policies and would reding the above listed policies.	(02.110)			
	developed by the ho	3, at 3:36 p.m. LALD-B stated provided for the licensee's vas all she had.				
{03000} SS=E	626.557 Subd. 3 Tir	ming of report	{03000}			
	believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry point vulnerable adult sol admitted to a facility required to report so individual that occur unless:	orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the red prior to admission,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			·		R	
		30630	B. WING		01/11/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
		AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{03000}	Continued From pa	ge 62	{03000}			
	another facility and believe the vulneral previous facility; or (2) the reporter knothat the individual is in section 626.5572 (a), clause (4). (b) A person not recprovisions of this sedescribed above. (c) Nothing in this sknown or suspected knows or has reason been made to the condition of the control of	the reporter has reason to oble adult was maltreated in the ws or has reason to believe a vulnerable adult as defined a subdivision 21, paragraph quired to report under the ection may voluntarily report as ection requires a report of dimaltreatment, if the reporter on to know that a report has ommon entry point. ection shall preclude a eporting to a law enforcement orter who knows or has not an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the may provide to the common ly to the lead investigative explaining how the event nder section 626.5572, agraph (c), clause (5). The gency shall consider this naking an initial disposition of bidivision 9c.				
		and record review, the				

Minnesota Department of Health

licensee failed to immediately report to the

Minnesc	Minnesota Department of Health					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			,
		30630	B. WING		R 01/11/2	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
1101110 0	AUSTIN,		VN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
{03000}	Continued From pa	ge 63	{03000}			
	Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse for two of two residents (R9, R1).					
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).					
	The findings include	e:				
		d immediate report to MAARC physical and verbal abuse.				
	R9 R9's diagnoses incl	uded dementia.				
	incidence was Nove of the incident indic (ULP) reported she into her wheelchair to "shut up". R9 was ULP also stated she shut up during one no other witnesses.	t identified estimated date of ember 8, 2022. A description ated an unlicensed personnel saw ULP-J forcing R9 back by her shoulders and told R9 s not able to confirm or deny. e heard ULP-J telling R9 to of her behaviors. There were "This staff member [ULP-J] t day and no longer works				
	Submitted was Tue	identified Date/Time sday November 15, 2022, at ays after date of incidence aber 8, 2022).				

Minnesota Department of Health

PRINTED: 02/02/2023 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		20620	B. WING			R
		30630			01/	11/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW			
IXOMIO O	OK HOUGE LLO	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{03000}	Continued From pa	ge 64	{03000}			
	of incidence was Not description of the in wanting more coffer minute and then toll would get some in a statement provided is seeing this report Assistant director has schedule while she [ULP-J] no longer was the last time should be made to the manufacture of	t identified the estimated date ovember 8, 2022. A reident indicated R1 was e and ULP-J ignored him for a d him to "shut up" and she a minute. This was the by a staff person. "This nurse for the first time today, ad taken [ULP-J] off of the completed the investigation. For was in the facility." identified Date/Time sday November 15, 2022, at any after date of incidence				
	2022, indicated date at 8:15 a.m. assista and found multiple note read "11/8/22 [ residents. She yells them to shut up. Wi food she either ignorannot have anymoresident care assist second note reads: residents. I heard hasked for more coff up during one of he standing up I saw [l shoulders and force wheelchair. This was	nary event date November 9, 2022, and time November 9, 2022, and director reported to work notes on her desk. The first (ULP-J) is really mean to at [R1] and [R9] and tells hen the residents ask for more present them or tells them they are." "This note was written by tent (RCA) [ULP-K]." "The [ULP-J] is very rude to the er tell [R1] to shut up when he fee. She also told [R9] to shut r behaviors. When [R9] was JLP-J] grab [R9] by the endown into her as also dated 11/8/22 written the Investigation Summary				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
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NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
[vulnerable adult] re On January 9, 2022 nurse (RN)-C state incidences above " random notes. We was off a few days should of been filed investigation notes stated the former li (LALD-A) said to w MAARC report). RI and informed staff  The licensee's Rep Neglect, Stealing, I indicated team mer witnessed question communication (veresident/tenant, car visitor, or non-care suspicions to the d staff immediately a if they have all the feelings or assump indicated the state reporting immediat the director or assis any unexplained in reporter has reason	n November 15, 2022, "VA eport was completed."  2, at 2:01 p.m. registered d, "We became aware" of the on November 9". "Staff left had to do an investigation. I between. I realized they d days ago. I waited until came back to us." RN-C censed assisted living director ait with reporting (filing a N-C stated we educated staff "call, no notes."  Porting Resident/Tenant Abuse, Etc. Policy revised April 2022, mbers who suspect or have table activities (physical) or regiver or other team member, giver are required to report the irector or other management and confidentially, regardless of facts or are unsure of their tions. The policy further of Minnesota requires ely, regardless of the facts, by stant director to the MAARC juries, which are defines as if a n to believe that the vulnerable d an injury which is not ed.	{03000}	DETICIENCY)		

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Protecting, Maintaining and Improving the Health of All Minnesotans

#### NOTICE OF CONDITIONAL LICENSE

**Electronically Delivered** 

October 19, 2022

Administrator KSMS Our House, LLC 204 14th Street Northwest Austin, MN 55912

RE: Conditional License Number 408631

Health Facility Identification Number (HFID) 30630

Project Number(s) SL30630015

### Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on September 12, 2022 for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on January 17, 2023.

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

### **IMPOSITION OF FINES**

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

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

KSMS Our House, LLC October 19, 2022 Page 2

§ 144G.20.

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

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

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

```
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000 St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000
```

The total amount you are assessed is \$6,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

## **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

KSMS Our House, LLC October 19, 2022 Page 3

with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to Health.HRD.Appeals@state.mn.us.

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

#### **Conditional License Issued:**

MDH will issue KSMS Our House, LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if KSMS Our House, LLC is in compliance.

The following conditions apply on the conditional assisted living facility license:

- a. No new substantiated maltreatment allegations: If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- **b. No new admissions:** KSMS Our House, LLC will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. KSMS Our House, LLC must provide the Department:
  - i. A list of the names and birthdates of any individuals KSMS Our House, LLC is currently in the process of admitting. These individuals will be able to

continue the admittance process.

- ii. A list of all current residents by location including:
  - 1. Name and birthdate of each resident
  - 2. Physical location of each resident
  - 3. Current payment source for services
  - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
  - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. Consultant: KSMS Our House, LLC will contract with an RN to provide consultation concerning all resident(s) to whom KSMS Our House, LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from KSMS Our House, LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with KSMS Our House, LLC and MDH must review the RN's credentials and approve the selection. KSMS Our House, LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to KSMS Our House, LLC in an effort to help KSMS Our House, LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. KSMS Our House, LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.
- d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies KSMS Our House, LLC and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:
  - i. Progress towards correction of licensing orders;
  - ii. Observations of staff delivering assisted living services and the level of competency observed;
  - iii. Conversations with residents and family members about satisfaction with assisted living services;
  - iv. Conversations with staff about their level of knowledge about the tasks they

- perform, the people they serve and the health professionals who delegate to them;
- v. Overall impressions about the quality of the assisted living services delivered;
- vi. Overall impressions about the dignity with which the residents and their family members are treated;
- vii. Concerns; and
- viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of KSMS Our House, LLC to correct the violations cited during the evaluation as well as to determine the overall practice of KSMS Our House, LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- **f. Follow-up Evaluation:** At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- **g.** Corrective Action Plan: KSMS Our House, LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
  - i. A statement of the concern
  - ii. A description of what will happen to correct the concern
  - iii. A target date for when each correction will be complete
  - iv. Who is responsible to make sure it happens
  - v. Current status of correction work
  - vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

## **Results of Follow-Up Survey During the Conditional License Period:**

MDH will determine if KSMS Our House, LLC is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines KSMS Our House, LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from KSMS Our House, LLC's assisted living facility license, and KSMS Our House, LLC will correct violations identified during the evaluation to come into full compliance. If MDH determines KSMS Our House, LLC is not in substantial compliance, MDH may take additional enforcement action against KSMS Our House, LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

# Request a Hearing:

Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

Maria King, RN **Division Director** 

Maria King

Minnesota Department of Health Health Regulation Division

**PMB** 

MILLIFOO	Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		I COMPI	-E I EU	
		30630	B. WING		09/12/2022		
					1 03/1	LILULL	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
KeMe O	UR HOUSE LLC	204 14TH	ST NW				
KSWIS O	UK HOUSE LLC	AUSTIN, N	/N 55912				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE	
				BEI TOILING!)			
0 000	Initial Comments		0 000				
	Initial comments						
	*****ATTENTION*	****		Minnesota Department of Health is	s		
				documenting the State Licensing			
	ASSISTED LIVING	PROVIDER LICENSING		Correction Orders using federal so	oftware.		
	<b>CORRECTION OR</b>			Tag numbers have been assigned			
		,		Minnesota State Statutes for Assis			
	In accordance with	Minnesota Statutes, section		Living License Providers. The assi	igned		
		5, these correction orders are		tag number appears in the far-left			
	issued pursuant to a survey.			entitled "ID Prefix Tag." The state			
				number and the corresponding tex			
	Determination of wh	hether violations are corrected		state Statute out of compliance is	listed in		
	requires compliance	e with all requirements		the "Summary Statement of Defici	encies"		
	provided at the Stat	tute number indicated below.		column. This column also includes	s the		
		tatute contains several items,		findings which are in violation of th	e state		
	failure to comply wi	th any of the items will be		requirement after the statement, "	This		
	considered lack of	compliance.		Minnesota requirement is not met	as		
				evidenced by." Following the surve			
	INITIAL COMMENT	ΓS:		findings is the Time Period for Cor	rection.		
	SL30630015						
				PLEASE DISREGARD THE HEAD	DING OF		
		022, through September 12,		THE FOURTH COLUMN WHICH			
		a Department of Health		STATES, "PROVIDER'S PLAN OF			
		at the above provider, and		CORRECTION." THIS APPLIES T			
	•	ction orders are issued. At the		FEDERAL DEFICIENCIES ONLY.	THIS		
		here were 17 residents; all of		WILL APPEAR ON EACH PAGE.			
		ng services under the		THERE IS NO REQUIREMENT T	$\circ$		
	-	Living with Dementia Care		THERE IS NO REQUIREMENT TO			
	license.			SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA ST			
	On Sentember 9 2	022, the immediacy of		STATUTES.	AI E		
		310 has been removed;		OTATOTEO.			
		oliance remains at a level 3,		The letter in the left column is use	d for		
	isolated (G).	silando romanio at a lovoi o,		tracking purposes and reflects the			
	.55.4.64 (0).			and level issued pursuant to 144G			
	On September 9. 2	022, the immediacy of		subd. 1, 2 and 3.			
	correction orders 1750 has been removed;			, =			
		pliance remains at a level 3,					
	widespread (I).	-,					
	,						

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM 6899 Y97111 If continuation sheet 1 of 169

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
0 110	Continued From pa	ge 1	0 110			
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required		0 110			
	Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.					
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD-A) was listed as the Director of Record for the licensee and had completed a shared license application for utilizing LALD-A's license for three separate (assisted living/assisted living with dementia care facilities) building locations. This had the potential to affect all the licensee's residents, staff, and visitors.					
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).					
	The findings include	e:				
	a.m. LALD-A's licer posted in the entrar	022, at approximately 10:00 nse for LALD was observed nce area of the facility. LALD-A he LALD for three separate				
		022, at 12:04 p.m. the f Executives for Long-Term				

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		20020		B. WING		0/0000
		30630			09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 110	Continued From pa	ge 2	0 110			
	Services and Support (BELTSS) website was checked for verification of assisted living director licensure for LALD-A. The website had no listed organization for Director of Record below LALD-A's name.					
	On September 6, 2022, at 12:20 p.m. a representative of BELTSS informed via email LALD-A was not listed as a shared license holder for three locations and she would need to apply for a shared license, in which after completing the application a license wall certificate would be provided for each location. The representative of BELTSS also informed LALD-A was not listed as Director of Record for any location.					
	stated she had rece	022, at 2:56 p.m. LALD-A eived an email from the ELTSS regarding what she				
	No further informati	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Two (2)				
0 250 SS=F	144G.20 Subdivisio	on 1 Conditions	0 250			
	provisional license, result of a change i a license, suspend a conditional licens individual, or emplo facility: (1) is in violation of,	ner may refuse to grant a refuse to grant a license as a n ownership, refuse to renew or revoke a license, or impose e if the owner, controlling yee of an assisted living or during the term of the d, any of the requirements in oted rules;				
	(2) permits aids or	abets the commission of any				

Minnesota Department of Health

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Minneso	<u>ta Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 250	illegal act in the proservices; (3) performs any act safety, and welfare (4) obtains the licer misrepresentation; (5) knowingly make material fact in the any other record or chapter; (6) denies represent access to any part of files, or employees; (7) interferes with othe department in coresidents; (8) interferes with othe department in the department in the department in the department in the fails to fully coopsurvey, or investigat (10) destroys or material or or other evidence refacility's compliance (11) refuses to initiate section 144.057 or (12) fails to timely promissioner; (13) violates any local relating to housing of (14) has repeated in performing services level; or (15) has operated to assisted living facility	exision of assisted living  at detrimental to the health, of a resident; ase by fraud or  as a false statement of a application for a license or in report required by this  attatives of the department of the facility's books, records, in impedes a representative of contacting the facility's  ar impedes ombudsman of section 256.9742,  ar impedes a representative of the enforcement of this chapter are with an inspection, attion by the department; alkes unavailable any records aleating to the assisted living as with this chapter; ate a background study under 245A.04; any any fines assessed by the and city, or township ordinance or assisted living services; ancidents of personnel as beyond their competency  beyond the scope of the ty's license category.	0 250	DEFICIENCY)		
		contractor providing the ices of the facility is a violation				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	204 14TH	ST NW	STATE, ZIP CODE		
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0 250	by the facility.  This MN Requirements: Based on interview licensee failed to shoof licensure, by attervitous who oversaw the day understood applicated developed and/or in and procedures as reviewed. This had residents, staff, and This practice results violation that did no safety but had the president's health or cause serious injury is issued at a wides are pervasive or rephas affected or has portion or all of the The findings included During the entrance 2022, at approximal assisted living directlicensee's employed were familiar with the and the licensee protection. The licensee's Appl License, section title Owner or Authorize the application), idea	and record review, the low they met the requirements sting the managerial officials ay-to-day operations ole statutes and rules; nor implemented current policies required with records the potential to affect all visitors.  The din a level two violation (a tharm a resident's health or intential to have harmed a safety, but was not likely to ay, impairment, or death), and pread scope (when problems bresent a systemic failure that the potential to affect a large residents).  The conference on September 6, tely 10:27 a.m. licensed tor (LALD)-A stated the less in charge of the facility in assisted living regulations by the assisted living regulations ovided medication and ment services.  The cation for Assisted Living and Official Verification of the dagent, (page four and five of intified, I certify I have read following: [a check mark was incompleted to the content of the content o	0 250			

Minnesota Department of Health

STATE FORM 6899 Y97111 If continuation sheet 5 of 169

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	I ST NW MN 55912			
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0 250	Continued From page 5		0 250			
	[Minnesota] Stat. [s 144G.45, my building subdivisions 1-3 of section Laws 2020,	ully understand Minn. statute] sect. [section] ng(s) must comply with the section, as applicable , 7th Spec. [special] Sess napter] 1. art. [article] 6, sect.				
	- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.					
	- Assisted Living Lichpt. 144G.	censure statutes in Minn. Stat.				
	- Assisted Living Li- Rules, chpt. 4659.	censure rules in Minnesota				
	- Reporting of Maltr	reatment of Vulnerable Adults.				
	- Electronic Monitor	ring in Certain Facilities.				
	Rights of Subjects use information promay include an in-promay include an in-promay include an in-promay include an in-promated information or the significant of my application of a license. I understated to the commissione some circumstance	uant to Minn. Stat. sect. 13.04 of Data, the Commissioner will ovided in this application, which person or telephone ermine if the applicant meets esisted living licensing. I ot legally required to supply the ion; however, failure to provide submission of false or tion may delay the processing r may be grounds for denying and that information submitted er in this application may, in es, be disclosed to the ederal or local agency and law				

Minnesota Department of Health

STATE FORM 6899 Y97111 If continuation sheet 6 of 169

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	LILULL
KSMS O	UR HOUSE LLC	204 14TH	_			
	0.18.844.537.074	· ·	MN 55912			
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0 250	Continued From pa	ge 6	0 250			
	enforcement office to enhance investigative or enforcement efforts or further a public health protective					
	process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.					
	- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.					
	I attest that I have r and Minnesota Rule the provision of ass understand as the I responsible for the operation of the fac	the owner or authorized agent, read Minn. Stat. chapter 144G, es, chapter 4659 governing sisted living facilities, and icensee I am legally management, control, and sility, regardless of the agement agreement or				
	attachments and chindicating my review Minnesota Statutes related to assisted my knowledge and true, correct, and cowriting, of any chan required.	this application and all necked the above boxes w and understanding of the Rules, and requirements living licensure. To the best of believe, this information is complete. I will notify MDH, in the set to this information as				
	- I attest to have all	required policies and				

Minnesota Department of Health

STATE FORM 6899 Y97111 If continuation sheet 7 of 169

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30630		B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 250	Continued From page 7		0 250			
	procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.					
	Page five was elect May 24, 2022.	ronically signed by LALD-A on				
	The licensee had an assisted living license issued on August 1, 2022.					
	policies and proced implemented: -requirements in se maltreatment of vul -training, and comp -handling complaint provided by staff; -conducting ongoing assessments of result assessments by a resident's condition and communicated providers as appropiation to and iliving bill of rights; -infection control preconducting appropiation of periodical staff are free of tube current United State and Prevention stare-delegation of tasks licensed health professionals.	etency evaluations of staff; is regarding staff or services or gresident evaluations and sident needs, including registered nurse or appropriate fessional, and how changes in on are identified, managed, to staff and other health care oriate; implementation of the assisted actices; riate screenings, or rior screenings, to show that erculosis, consistent with es Centers for Disease Control adards; atment management; is by registered nurses or				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
	I	AUSTIN, N	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 250	Continued From pa	ge 8	0 250			
	were issued 0510, 0 1420, 1440, 1620, 1 1820, 1880, 1940, 1 and 3000, indicating of the Minnesota sta	urvey, the following orders 0620, 0630, 0660, 1370, 1380, 1710, 1730, 1750, 1760, 1790, 1950, 1960, 1970, 2310, 2480, g the licensee's understanding atutes were limited, or not noce with Minnesota Statutes, 144G.95.				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 470 SS=F	144G.41 Subdivisio	n 1 Minimum requirements	0 470			
	determining its staff (i) includes an evalu- least twice a year, of staffing levels in the (ii) ensures sufficier the scheduled and runscheduled needs by the residents' as on a 24-hour per da (iii) ensures that the and effectively to in- and to emergency, situations affecting (12) ensure that one available 24 hours p who are responsible requests of resident safety needs. Such (i) awake; (ii) located in the sa building, or on a con-	pation, to be conducted at of the appropriateness of a facility; at staffing at all times to meet reasonably foreseeable of each resident as required sessments and service plans by basis; and a facility can respond promptly dividual resident emergencies life safety, and disaster staff or residents in the facility; are or more persons are per day, seven days per week, as for responding to the staff or assistance with health or				

Minnesota Department of Health STATE FORM

DRM 6899 Y97111 If continuation sheet 9 of 169

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30630	B. WING	B. WING		2/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
(iv) capable of providi appropriate assistance (v) capable of following This MN Requirement by: Based on interview and licensee failed to ensure developed to determineds of all residents schedule was posted information. This had residents, staff and violation that did not he safety but had the polyresident's health or saccuse serious injury, was issued at a wides problems are pervasificallure that has affected a large portion or all of the scheduled and resumble scheduled and resumble scheduled needs of by the residents' asset on a 24-hour per day ensured that the faction of the scheduled to individual the faction of the scheduled that the scheduled	unicating with residents; ing or summoning the ce; and and directions; at is not met as evidenced and record review, the cure the staffing plan was the staffing levels to meet the staffing level to affect all isitors.  If in a level two violation (a charm a resident's health or tential to have harmed a cafety, but was not likely to impairment, or death), and spread scope (when the staffing level that the staffing at all times to meet the sonably foreseeable of each resident as required desiments and service plans basis; and cility can respond promptly vidual resident emergencies de safety, and disaster	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 470	Continued From pa	ge 10	0 470			
	On September 6, 2022, at approximately 10:27 a.m. during the entrance conference, registered nurse (RN)-C stated, "Yes" a staffing plan had been developed. The surveyor requested information regarding the licensee's staffing plan.					
	stated the licensee stated she found an about staffing plan, she could not find a	022, at 12:37 p.m. RN-C had no staffing plan. RN-C nemail regarding "discussion looking for more hours", but plan. RN-C stated, "The ctical nurse (LPN)-G] that did				
	provided the email is staffing. The email indicated the discussions scheduled staff hou "looking for more" in	022, at 12:54 p.m. RN-C regarding the discussion of was dated April 21, 2022, and sion was about increasing ars. RN-C stated she was a staffing RN-C stated she had "no				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 485 SS=C		3) (i) (A) and (C) Minimum	0 485			
	(13) offer to provide following services to	or make available at least the presidents:				
	available seven day recommended dieta States Department	ritious meals daily with snacks as per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30630	B. WING		09/12/2022	
NAME OF PROVIDER OR SUPP		, ,	STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN,	MN 55912			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
(A) menus must advance, and rescility must en menu planning similar nutrition food that is ser in advance of resciling and pay for medical the facility of the fac	s. The following apply:  It be prepared at least one week in hade available to all residents. The courage residents' involvement in Meal substitutions must be of all value if a resident refuses a yed. Residents must be informed henu changes;  annot require a resident to include als in their contract;  Therefore the following and record has a failed to ensure at least three and also also and the potential to affect all 17  sulted in a level one violation (and its no potential to cause more than contract and does not safety) and was issued at a spe (when problems are pervasive systemic failure that has affected to affect a large portion or all of				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
	PROVIDER OR SUPPLIER UR HOUSE LLC	STREET ADI <b>204 14TH</b> <b>AUSTIN, N</b>	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 485	addition, the license licensee's weekly no recommended daily to USDA guidelines. On September 6, 2 a.m. during the entirequested information menu.  LUNCH MEAL SEFON September 6, 2 of the dining roome indicated for "lunch" salad, spaghetti, go 12:30 p.m., unlicentobserved to serve the residents. The food with meat sauce, go preference (juice, not another unidentified kitchen and placed marshmallows and mixed up the ingree mixture was "fruit fluther. ULP-D was observeresidents. ULP-D desidents. U	ry: three serving per day). In see failed to ensure the nenu included the y dietary allowances according is.  022, at approximately 10:27 rance conference, surveyor ion for the licensee's weekly  RVED  022, at 11:21 a.m. observation chalk board on the wall  " the food to be served was arlic bread, ice cream". At sed personnel (ULP)-D was the lunch meal to the d ULP-D served was spaghetti arlic toast and drinks of nilk, coffee, water). At the time d staff person came into the a can of fruit cocktail, whip cream into a bowl and dients. ULP-D stated the uff" and was the desert. The details of the deserved to id not serve the residents from "Tuesday lunch" the does exerved: "tossed green the meat sauce, garlic bread, of the day], LF [low fat] milk 4 menu lacked a listed fruit to be	0 485			

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winnesc	<u>ita Department of He</u>	eaith				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAIN	O. JOHNLOHON	DENTIFICATION NOWIDER.	A. BUILDING:	<del></del>		
			B. WING			
		30630	D. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
		AUSTIN, I	/N 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 485	Continued From pa	ge 13	0 485			
	The "week 3" menumere listed for mean Sunday Breakfast: juice of occreal, eggs, sausafresh fruit, LF milk & Lunch: dinner rolls, potatoes, brown grapumpkin pie, LF min Dinner: bread, hot is pea salad, peanut & Monday Breakfast: juice of occreal, strawberry with 8 oz. Lunch: bread, Saliscarrot coins, frosted Dinner: navy bean see the sunday breakfast.	i identified the following foods ls:  choice, assorted hot/cold age link, blueberry muffin, 3 oz. roast turkey, mashed avy, broccoli and cauliflower, lk 4 oz. ham and cheese sandwich, butter bars, LF milk 4 oz.  choice, assorted hot/cold waffle, fresh seasonal fruit, LF bury steak, baked potatoes, d yellow cake, LF milk 4 oz. soup, crackers, garden tuna				
	sandwich, fruit cup, LF milk 4 oz.  Tuesday Breakfast: juice of choice, assorted hot/cold cereal, scrambled eggs, raisin toast, fruit, LF milk 8 oz. Lunch: tossed green salad, spaghetti with meat sauce, garlic bread, ice cream du jour, LF milk 4 oz.  Dinner: bread, chicken pot pie, beets, rainbow gelatin, LF milk 4 oz.  Wednesday Breakfast: juice of choice, assorted hot/cold cereal, pancakes with syrup, sausage patty, fresh seasonal fruit, LF milk 8 oz. Lunch: dinner rolls, orient pork cutlets, chicken rice, oriental vegetables, spice cake, LF milk 4 oz. Dinner: very vegetable soup, crackers, Grilled turkey and Swiss, peanut butter cookies scratch, LF milk 4 oz.					

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED	
			D 14/11/0			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 485	Continued From page 14		0 485			
	cereal, scrambled eseasonal fruit, LF m Lunch: bread meat potatoes, corn, Dutmilk 4 oz. Dinner: cheese sou croissant, nila bana Friday Breakfast: juice of cereal, biscuits/sau fruit, LF milk 8 oz. Lunch: bread, bake applesauce, marble Dinner: tossed gree	loaf, brown gravy, mashed ch apple pie with cr top, LF ip, crackers, chicken salad on ina pudding, LF milk 4 oz.  choice, assorted hot/cold sage gravy, fresh seasonal id fish, baked tater tots, e cake, LF milk 4 oz. en salad, salad dressing of et, lasagna, fruit Jello with				
	Saturday Breakfast: juice of choice, assorted hot/cold cereal, scrambled eggs, toast, fresh seasonal fruit, LF milk 8 oz. Lunch: dinner rolls, ham/potatoes/broccoli hotdish, mixed vegetables, peach cobbler, LF milk 4 oz. Dinner: club sandwich, carrot raisin salad, chips, molasses cookies, LF milk 4 oz.  On September 8, 2022, at 2:07 p.m. licensed assisted living director (LALD)-A stated regarding the lunch meal served as above, the head cook at another building was ordering the groceries for the licensee until ULP-D was trained in. LALD-A					
	a food service com "working on new on	ing utilized was provided from pany and the licensee was nes", but the licensee had not .D-A reviewed the licensee's				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
0 485	5 Continued From page 15		0 485			
	week three (3) mer not indicated on the other beverages lis LALD-A stated snaday, which included p.m. snack and HS verified the menu daily recommended served for vegetabl USDA guidelines. L listed "fruit or "fresh dates, but did not in served was. LALD always indicate what the state of the served was. LALD always indicate what the served was always which was always indicate what the served was always indicate what the serv	nu and verified snacks were emenu and there were no ted on the menu besides milk. cks were served three times a d an a.m. snack with activity, (bedtime) snack. LALD-A lid not consistently include the d dietary allowances to be le and fruit according to the LALD-A confirmed the menu in seasonal fruit" on some indicate what the fruit being -A confirmed the menu did not at protein was being served.				
0 510 SS=F	(a) All assisted livin maintain an infection complies with accenursing standards of (b) The facility's infectonsistent with currinational Centers for Prevention (CDC) of control in long-term applicable, for infectors assisted living facility (c) The facility must compliance with this	t maintain written evidence of	0 510			
		ion, interview, and record				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 510	review the licensee maintain an infection with accepted healt standards for infect recommendations for licensee failed to experience of the effective infection of with accepted healt standards for infect handwashing during administration for the transport of the president's health or widespread scope or represent a system or has the potential of the residents).  The findings include POSTED SCREEN The licensee failed for COVID-19 at faction of the facility restrictions for infect COVID-19.  On September 7, 2 nurse (RN)-B observance to the facility restrictions for infect covidence of the facility entrance to the facility entrance to the facility restrictions for infect covidence of the facility entrance to the fa	failed to establish and on control program to comply th care, medical, and nursing ion control for current for COVID-19. In addition, the stablish and maintain an ontrol program that complies th care, medical and nursing ion control related to g medication and treatment wo of two residents (R2, R1). ital to affect all residents, staff ed in a level two violation (at tharm a resident's health or obtained to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all to post signage of restrictions	0 510			

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
KSMS O	UR HOUSE LLC	204 14TH	_			
	T	AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 17	0 510			
	RN-B stated, "I'm not sure what happened with that. It used to be up".					
	Prevention and Cor Healthcare Personr Disease 2019 (CON February 2, 2022, in aware of recomment facility. Post visual aposters) at the entra (e.g., waiting areas instructions about of (e.g., when to use shand hygiene). Dati	titled, Interim Infection introl Recommendations for hel During the Coronavirus /ID-19) Pandemic updated indicated ensure everyone is inded IPC practices in the alert icons (e.g., signs, ance and in strategic places in elevators, cafeterias) with current IPC recommendations is source control and perform ing these alerts can help in that they reflect current				
		to ensure handwashing before n administration.				
	and after medication administration.  On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer oral medications and an eye medication to R2. ULP-E applied gloves, placed R2's medications into a medication cup (removed from a basket in the licensee's medication closet), shut the medication closet door, walked down the hall, entered R2's room and placed each oral medication (eight tablets) separate into R2's mouth with the same gloves remaining on hands. With same gloves remaining on ULP-E placed one eye drop of eye medication onto each of R2's eyes. ULP-E had to hold open R2's eyes with gloved hand. ULP-E provided application of toe guards on R2's great toes. ULP-E walked out of R2's room and removed gloves. ULP-D failed to wash hands prior to administration of oral/eye					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	12/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KeWe O	UR HOUSE LLC	204 14TH	ST NW			
KSIVIS U	OK HOUSE LLC	AUSTIN, I	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 18	0 510			
	medication and faile leaving R2's room.	ed to wash hands prior to				
	she would expect g hands cleansed wit the bathroom before medications and pri R1 The licensee failed following treatment On September 7, 20	to ensure handwashing of blood sugar testing.  022, at approximately 1:00				
	p.m. the surveyor observed ULP-E in the medication room prepare blood sugar testing equipment for R1. ULP-E stated that blood glucose checks are done four times daily as indicated on the electronic Medication Administration Record (e-MAR). ULP-E gathered blood glucose equipment in R1's labeled container and gloves, and went to R1's room. ULP-E identified R1 by name and told him that she would like to check his blood sugar. He agreed and provided his left hand. ULP-E applied					
	the end of R1's mid wipe, allowed to dry outside of middle fir that was placed on The lancet was place that held the testing provided R1 with a area. The glucome reading of 93. ULP-container and return unlocked the medic same gloves, place container, removed document blood glu	d equipment. ULP-E wiped dle finger with an alcohol and then used lancet to poke ager creating a drop of blood the test strip in glucometer. Seed on the lid of the container equipment. ULP-E then cotton ball to hold at poked a blood glucose and E gathered equipment and and to the medication room, sation room door with the d the lancet in the sharps the gloves and continued to acose reading in the electronic ULP-E then closed medication.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/202	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/1	212022
KSMS OUR HOUSE LLC 204 14TH AUSTIN,		ST NW IN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 510	closet door and lock ULP-E touched mu hands following glu wash hands followin On September 12, p.m. RN-B stated th about using good in are expected to ren The licensee's Nove policy dated June 2 director was respor residents, staff, fam regarding the precaprotect residents ar indicated there were be posted in your lof families, visitors, re	ked it.  Altiple surfaces with her gloved cose testing and failed to an glove removal.  2022, at approximately 12:00 and they just had a discussion affection control and that staff move gloves and wash hands.  Bel Coronavirus-19 Procedure 020, indicated the executive asible for communication with allies and regular visitors autions taken by the location to and staff. The policy further a posters available that could ocation to provide guidance to sidents, and team members.	0 510			
0 550 SS=F	All facilities must poinformation about the e-mail contact information are responsible for The notice must als information for the Office of Ombudsmann the Office of Ombud	esident grievances; reporting  ost in a conspicuous place ne facilities' grievance name, telephone number, and mation for the individuals who handling resident grievances. so have the contact state and applicable regional lan for Long-Term Care and dsman for Mental Health and abilities, and must have	0 550			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 550	This MN Requirements by: Based on observation review, the licensed related to the grieval potential to affect a safety but had the president's health or cause serious injury was issued at a wide problems are perval failure that has affer a large portion or all the findings include.  The licensee lacked location and a discliniclude:  -the name, telepholinformation for the irresponsible for hand-the contact information for the irresponsible regional Long-Term Care are for Mental Health a and must have info suspected maltreat Abuse Reporting C.	orting suspected maltreatment dult Abuse Reporting Center.  ent is not met as evidenced on, interview, and record efailed to post information ance procedure. This had the ll residents, staff and visitors.  ed in a level two violation (a tharm a resident's health or obtential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when asive or represent a systemic cted or has potential to affect ll of the residents).  e:  d postings in a conspicuous osure of resident advocacy to the number, and e-mail contact andividuals who are dling resident grievances; ation for the state and Office of Ombudsman for and the Office of Ombudsman and Developmental Disabilities, rmation for reporting ment to the Minnesota Adult enter	0 550			
	of information poste procedure included	022, at 11:30 a.m. observation ed for the facility grievance information of the licensee's ee and was posted in an				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	_			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 550	· ·		0 550			
0 570 SS=C	The original current the main entrance of the facility must properly any person who recommend this MN Requirements.	on 1 Display of license  It license must be displayed at of each assisted living facility. Ovide a copy of the license to quests it.  The property of the license of the li	0 570			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	204 14TH		STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	AUSTIN, M				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 570	Continued From pa	ge 22	0 570			
	failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors.  This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).					
	The findings include:					
	On September 6, 2022, at approximately 10:00 a.m. upon entering the building, the facility's license was not observed to be displayed or posted at or near the main entrance as required. At 11:30 a.m. surveyor observed the license posted on a wall outside the nursing office which was accessed from the dining room.					
	p.m. during observativing director (LALI current license was the nursing office at main entrance of the stated she was awardisplayed at the ma	022, at approximately 2:03 ation with licensed assisted D)-A, LALD-A confirmed the posted on a wall outside of and was not displayed at the e facility as required. LALD-A are the license was to be in entrance of the facility. on't know why there and not e."				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				

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	ta Department of He	1	T		I	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN OF CORRECTION IDENTIFICATION NOWIDER.		A. BUILDING:				
		D. WING				
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW			
1101110	OK 110002 220	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 23	0 620			
0 620 SS=E			0 620			
	144G.42 Subd. 6 (a) Compliance with					

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
30630		B. WING		09/12/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 620	a thorough investig interviews related to R3's diagnoses incloss).  R3's Resident Ever following: -dated August 8, 20 resident altercation walker at resident # follow up actions: R incident. When nurstated "it did not hit -dated August 22, 2 resident altercation #12 [R3] were in the #16 asked R3 if he women (referring to getting aggressive started hitting R3 wand follow up action incident the two resident shows no cane. Staff would s	evidence of documentation of ation of staff and resident to the altercations.  Juded dementia (memory  at Reports included the  21, indicated resident to  Resident #1 (R2) threw her  212 (R3). Other outcome and  Resident shows no injury from see asked him about it, R3	0 620			
	-dated August 24, 2021, indicated resident to resident altercation. Staff entered resident #16's room to take a blood glucose test. Resident #12 [R3] was in resident #16's room. Resident #16 had R3's genitals in her mouth. Staff asked R3 to leave resident #16's room. Other outcome and follow up actions: resident shows no injury from incident. Resident #16 and R3 have had a very close relationship since she was admitted. From staff observation this relationship is consensual from both residents. Residents' power of attorney					

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Millieso	ita Department of He	eaith	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
30630		B. WING		09/12/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		204 14TH	, ,	,		
KSMS O	UR HOUSE LLC		MN 55912			
(Y4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI IGIERGT)		
0 620	Continued From pa	ge 25	0 620			
	(POA) was contacte	ed and agreed relationship				
		ooth resident parties agree the				
		. Staff would intervene if				
	needed due to all p	arties not agreeing yet to				
	relationship betwee	n the two residents.				
	lata l O antanakan	40.0004 :- 1: 1: 1				
	•	10, 2021, indicated resident to				
		Resident #12 [R3] was sitting ont when resident #16 started				
		ried to lunge at him. This writer				
		and called for help. Resident				
were able to be redirected						
	ceased. Other outcome and follow up actions: per staff report resident #16 has been accusing R3 of cheating on her. Resident #16 becomes very tearful when she thinks this and at times does					
		th resident. Staff continue to				
		and intervene and separate				
	the resident's if nee	eded.				
	R3's record include	d the following MAARC				
	reports:					
	•	mitted Wed. September 1,				
		ndicated on August 30, 2021,				
		d resident #16 have engaged				
		ship with one another. Staff				
		exual act between the two				
		dents have consented to the				
		esidents' POAs are aware of I have agreed they may				
	engage in the relati					
	Singago in the relati					
	On September 8, 2	022, at 12:56 p.m. registered				
		d she had no other MAARC				
	reports for the above	e resident to resident				
		stated both residents (R3 and				
		dementia diagnosis. RN-B				
		ify who resident #16 was, and				
		ook for more information				
	regarding the above	e Resident Event Reports.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	DING: (X3) DATE COMF		SURVEY LETED
30630		B. WING		09/12/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADD  204 14TH				STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 26	0 620			
	However, no furthe	r information was provided.				
	Continued From page 26 However, no further information was provided.  R2 The licensee lacked evidence of documentation of a thorough investigation of staff and other resident interviews related to the injury of unknown origin to determine if abuse occurred.  R2's diagnoses included dementia.  R2's MAARC report, date and time submitted Thursday, February 24, 2022, at 12:56 p.m. indicated on February 23, 2022, at 2:00 p.m. R2 was noted to have a bruise to left clavicle area around bra strap line. Area was yellow in color and follows a straight line along bra strap. Bruise measures 3 centimeters (cm) x 0.6 cm. R2 denies any abuse. R2 noted to have fall on February 15, 2022, that may have caused this bruising. Concern Regarding a Resident Update to bruise (complete) identified R2 was interviewed and R2 stated "I don't know" to the questions what happened, did you fall and did someone hurt you. An Injury or Bruise of unknown Origin Investigation dated February 23, 2022, indicate on February 15, 2022, resident was transferred via ambulance. Area of bruising matches with cot belt. R2's record lacked evidence of documentation of interviews completed with the licensee staff and other residents to determine if abuse occurred.  On September 8, 2022, at 10:46 a.m. RN-B verified R2's record lacked evidence of documentation of interviews completed with the licensee staff and other residents to determine if abuse occurred.					
R4 The licensee lacked immediate report to MAARC						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		20620	B. WING		09/12/2022	
		30630			09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD 204 14TH		STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 27	0 620			
	of documentation o staff, resident and o related to the injury determine if abuse					
	R4's diagnoses incl	luded dementia.				
	Thursday, May 26, on May 21, 2022, a have a swollen right painful with range of instructed to send for resident had a brok to have a fall on Masigns of pain at the Concern Regarding dated May 21, 2022 evening staff notice bigger than yesterd squeeze staffs han noticed "residents at to squeeze staff haknuckles, purple ar on call nurse around	t, date and time submitted 2022, at 9:40 a.m. indicated t 8:55 p.m. R4 was noted to t arm/hand and the area was of motion. The nurse on call R4 to the ER. It was found the ten right elbow. R4 was noted by 19, 2022, but showed no time of the fall or after. A grant a Resident Concern note 2, indicated at 3:00 p.m. this and "resident's arm had gotten by "Resident was able to d. During supper time staff farm got more bigger." Unable ands, unable to see her and warm to touch. Staff called d 8:20 p.m. and informed m. Resident was transferred to				
	stated she was "no reported late to MA	022, at 10:46 a.m. RN-B t sure why" the R4's injury was ARC. RN-B stated that's "all I ocumented information of R4's ve.				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS OUR HOUSE LLC 204 14TH AUSTIN, M			_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 630	Continued From page 28		0 630			
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma		0 630			
	individual abuse pre vulnerable adult. The individualized review person's susceptibile individual, including person's risk of abuse and statements of to taken to minimize the and other vulnerable abuse prevention places.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults for two of two residents (R2, R1).					
	This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).					
	The findings include	e:				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/202	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS O	UR HOUSE LLC	204 14TH	_			
		<u> </u>	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 630	0 Continued From page 29		0 630			
	personnel (ULP)-E medications to R2.  R2's 90-day assess indicated for "self p risk for abuse, negl the description for t "resident will be free next review date. B resident, observation preservation assess vulnerable, but ther neglect. Resident d threat to other vulne assessment further assessment for "sh themselves or othe	included an area of ows signs of physical abuse to rs" which included approaches nt when R2 would become				
	susceptibility to abuincluding other vuln R1 On September 7, 2	iled to address R2's use by another individual, erable adults as required. 022, at approximately 11:00 userved to complete R1's blood				
	R1's 90-day assess indicated for "self p risk for abuse, negl description for the iresident will be free next review day bas observation, guardi	sment dated August 16, 2022, reservation" R1 was a safety ect, and misappropriation. The dentified risk indicated e of abuse and neglect until sed on interview from resident an and self preservation ent is vulnerable, but there are				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	STREET ADI <b>204 14TH</b> <b>AUSTIN, N</b>	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 630	no signs of abuse of appear to pose a the adults." The assess assessment that independent and exhibited verball. The assessment fassessment fassessment fassessment fassesptibility to abuse including other vuln. On September 12, nurse (RN)-B stated prevention plans we assessments computed, "That's all we content mentioned R2 and R1. RN-B van individualized re R1's susceptibility to including other vuln.	or neglect. Resident does not reat to other vulnerable sment also included an area of dicated signs of physical ers, and indicated strategies nt when R1 became upset al aggression.  illed to address R1's use by another individual, erable adults as required.  2022, at 10:13 a.m. registered diresident's individual abuse ere integrated into the nursing eleted for residents. RN-B use have" referring to the above for assessment of abuse for verified the assessment of R2 and to abuse by another individual, erable adults as required	0 630			
0 640 SS=F	reporting suspected The facility shall surthrough access to treporting suspected suspected vulnerability (1) posting the 911 common areas and the assisted living for the suspected suspected vulnerability (1) posting the 911 common areas and the suspected s	pport protection and safety he state's systems for d criminal activity and ele adult maltreatment by: emergency number in near telephones provided by	0 640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS C	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 640	for the Minnesota A to report suspected adult under section (3) providing reason information and not a support and the providing information and not a support proposting information reporting to the Mir Center (MAARC) a emergency number telephones provide This had the potent receiving assisted I visitors.  This practice result violation that did not safety but had the president's health or cause serious injur was issued at a wide problems are pervatallure that has affer a large portion or a support of the four phones availating 11 emergency MAARC information near the telephone on September 6, 2 on S	adult Abuse Reporting Center maltreatment of a vulnerable 626.557; and mable accommodations with tices in plain language.  The matter is not met as evidenced and interview, the licensee of tection and safety by not and phone numbers for an and phone numbers for an an area and near doubt a safety and failed to post the 911 and in common areas and near doubt a safety and safety and a level two violation (and tharm a resident's health or contential to have harmed a safety, but was not likely to any impairment, or death), and despread scope (when asive or represent a systemic content and the residents).  The matter is a vulnerable and in a level two violation (and tharm a resident's health or contential to have harmed a safety, but was not likely to any impairment, or death), and despread scope (when asive or represent a systemic content and the residents).  The matter is a vulnerable and in the resident and in the r	0 640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER	204 14TH		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 640	confirmed the 911 crequired MAARC in common areas and stated she "was aw No further informations."	with the surveyor and emergency number and the formation was not posted in near telephones. LALD-A are" of the requirement.	0 640			
0 660 SS=F	(a) The facility must comprehensive tuber program according tuberculosis infection the United States C and Prevention (CD Elimination, as publicand Mortality Week include a tuberculos covers all paid and contractors, student volunteers. The contechnical assistance the guidelines. (b) The facility must compliance with this This MN Requirement by:  Based on interview licensee failed to est (tuberculosis) prevents as the centers for Disest to the programment of the contents of the compliance to the programment of the centers for Disest to the centers for Disest the Company of	on control guidelines issued by senters for Disease Control DC), Division of Tuberculosis lished in the CDC's Morbidity ly Report. The program must sis infection control plan that unpaid employees, ts, and regularly scheduled mmissioner shall provide regarding implementation of st maintain written evidence of	0 660			

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winneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 660	Continued From pa	ge 33	0 660			
	all residents, staff and visitors.					
	violation that did no safety but had the president's health or cause serious injury was issued at a wid problems are pervafailure that has affe a large portion or all The findings include TB POLICY The licensee lacked procedure for the licenseam which add	•				
	written TB infection care worker (HCW)	control procedures and health education.				
		MENT e the licensee's TB Risk ated and included all required				
	provided was undate information for incident	acility risk assessment ted and lacked documented dence of TB. The risk ed the licensee was a low risk.				
	plan for the procedurecognition and referent with suspected or compared to the plant of the procedure.	d a written TB infection control ures to address early erral for handling residents confirmed active TB; therefore, e's employees had received				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW VIN 55912			
(VA) ID	STIMMADV STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 660	Continued From pa	nge 34	0 660			
0 660	On September 12, nurse (RN)-B state policy and procedu was not sure of the licensee's TB Risk. TB risk assessment information for the The MDH guidelines. Tuberculosis Contr. Settings" dated July guidelines, indicate Minnesota should hontrol program that for TB infection corrassessment; Writter procedures; Health education. TB infection control program that in the signs and symptems of the signs and symptems.	2022, at 12:22 p.m. registered d the licensee had no written re for TB. RN-B stated she date she completed the Assessment. RN-B verified the It lacked documented incidence of TB.	0 660			
	Isolation: Place a p in an airborne infec available; If not, pla with door shut. Ref	otentially infectious TB patient stion isolation (AII) room if ace patient in separate room erral: If your setting does not , transfer potentially infections				
	TB patients to a se evaluate and treat	tting that is equipped to TB patients. TB training is hire for all health care workers				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 660	and the content sho information: Your he control plan (i.e., ho recognition, isolatio	ould focus on basic ealth care setting's infection by to implement your early n, and referral procedure), ons that employees are ementing.  on was provided.	0 660			
0 680 SS=F	(a) The facility must requirements: (1) have a written e contains a plan for elements of shelter temporary relocation assignments in the emergency; (2) post an emergency; (2) post an emergency; (3) provide building all residents; (4) post emergency and (5) have a written pomissing tenant residents in the emergency and is aster training to a orientation and annotation and annotat	mergency disaster plan that evacuation, addresses ing in place, identifies in sites, and details staff event of a disaster or an incy disaster plan prominently; emergency exit diagrams to exit diagrams on each floor; olicy and procedure regarding	0 680			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC 204 14TH AUSTIN,					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
0 680	Continued From pa	ge 36	0 680			
	(c) The facility must meet any additional requirements adopted in rule.					
	This MN Requirements	ent is not met as evidenced				
	Based on observation review, the licensesse emergency disaster and was posted; fail diagrams were posted and failed to ensure procedure for mission required content. In develop an all-hazar (EP) program and prequired elements, all 17 residents, state This practice resultation that did not safety but had the president's health or cause serious injury was issued at a wide problems are pervafailure that has affer	ed in a level two violation (a t harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect				
	a large portion or al	,				
	contained a plan for elements of shelter temporary relocation assignments in the emergency; - posting of an eme prominently;	d the following: cy disaster plan that r evacuation, which addressed ing in place, identified n sites, and detailed staff event of a disaster or an rgency disaster plan emergency exit diagrams to all				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
KeWe U	UR HOUSE LLC	204 14TH	I ST NW			
KSWS U	UK HOUSE LLC	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 37	0 680			
	and - a written policy an missing tenant resid required content; ar - Appendix Z (emer requirements  EMERGENCY DISA On September 6, 20 tour of the facility, and a written policy and a written policy and a written policy are requirements.	gency preparedness) ASTER PLAN 022, at 11:30 a.m. during a n emergency plan with more				
	than one page was posted inside an enclosed glass case, which was not assessable to persons. At 2:03 p.m. observation of the facility with licensed assisted living director (LALD)-A, LALD-A confirmed the emergency plan posted in the enclosed glass case was not assessable to persons.					
	On September 7, 2022, at 9:53 a.m. the LALD-A provided a copy of the licensee's Emergency Management Plan dated January 7, 2017, via email. The plan described procedures for fire, missing resident, medical emergency, unresponsive- Full Code, unresponsive- Do Not Resuscitate (DNR), resident fall or injuries, medical issues that require immediate attention, infection control/contagious illness, pandemic outbreak, blood spill procedure, needle puncture-staff, maintenance emergency, elevator emergency, power outage/shortage, refrigerators/freezer not working, toilet, water heater, washing machine, dishwasher overflowing, discontinuation of water supply, gas leaks and carbon monoxide detector sounds, furnace not working, air conditioning not working, chemical spills in the immediate area, chemical spill shelter in place, evacuation of a chemical incident, chemical poisoning, storms, severe					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	<del></del>	COMP	LLILD
		30630	B. WING		09/12/2022	
			<u> </u>		09/1	ZIZUZZ
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
0 680	Continued From no	20	0 680			
0 000	Continued From pa		0 000			
	thunderstorm, winter					
		threat, terror alert, violent Crises Management for				
		r neglect/caregiver misconduct				
		the media; however the plan				
	did not address ele	ments of sheltering in place,				
		y relocation sites, and details				
	•	n the event of a disaster or an				
	emergency.  EMERGENCY EXIT DIAGRAM					
		022, at 11:30 a.m. during a				
		a diagram of the layout of the				
		was observed posted inside a e. The diagram lacked				
		t locations from the building.				
		ted emergency exit diagrams				
		n of the building. At 2:03 p.m.				
		facility with LALD-A, LALD-A				
		ram of the layout of the				
		he enclosed glass case did not ns from the building. LALD-A				
		ere no other posted emergency				
		y other location of the building.				
	On Contour box 7 0	000 at ammunimentals 10:04				
		022, at approximately 10:24 se (RN)-C stated, "We haven't				
		", regarding providing building				
		grams to all residents.				
	MISSING RESIDEN	NT DLAN				
		ident Elopement Policy dated				
		ated "team members" to				
		sident search, search the				
	building, courtyard,	walk around the outside of the				
		looking in available vehicles,				
		own the street. If team				
		locate the resident, contact stact the director for assistance				
		port. The director should				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	JR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 680	prepared to provide regarding the reside resident). Once the team members working and complete determine if any injunctify responsible president was found time team members whereabouts of the check reflects how.  The licensee lacked which included the -(1) identify a staff of responsible for impresident, and ensur who is responsible resident plan is one days a week; -(2) require that state identified in subiter suspected that a resuspected missing -(4) require that state thorough search of premises, and the iteach direction when missing; -(5) require that as considered missing after staff complete -(6) require that state enforcement when subitem (5) or other missing;	Team members need to be information to the police ent (information about the resident was located, the ald take the resident's vital a skin assessment to uries. The director should earty as to where and when the and determine the amount of should check the resident. The timing of the active the resident is.  If a missing resident plan following:  member for each shift who is lementing the missing the at least one staff member for implementing the missing site 24 hours a day, seven  If alert the staff member m (1) immediately if it is sident may be missing; position description who are reching for missing residents or	0 680			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER	204 14TH	DDRESS, CITY, ST I ST NW MN 55912	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 680	resident represental manager, if applicate determined missing (-(8) require that state enforcement and processary to identification resident.  On September 12, licensee's Resident August 2020, lacked APPENDIX Z REQUENTE The licensee lacked according to Emergization.  The licensee lacked information according to Emergization according to Emergization according reparedness: Apperestablish/maintain describes the facilith health/safety/securial addressing address other, health care facommunity on a whole with the end of the en	Itives and the resident's case ble, when a resident is grand iff cooperate with local law rovide any information that is grand locate the missing it and locate the missing it is a content.  UIREMENTS is required information gency Preparedness: Appendix it is a comprehensive EP which grandly it is approach to meeting the meeting it is a comprehensive EP which grandly it is approach to meeting the meeting it is a comprehensive in				

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MILLINESC	ita Department of He	eaun				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		-
NAIVIL OI I	-NOVIDEN ON SUFFEIEN		, ,	STATE, ZIF CODE		
KSMS OUR HOUSE LLC						
		<u> </u>	MN 55912			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
0 680	Continued From pa	ge 41	0 680			
	-					
		es/shortages, back-up plans);				
		risk population needs like				
		ndence, communication,				
		ervision, medical care, identify				
		ssume specific roles in through succession planning				
		uthority and qualified person				
		g to act in the absence of the				
	administrator;	g to dot in the absence of the				
	- a process for cooperation and collaboration with					
		II, State and Federal EP to				
	maintain integrated					
		ure based on the EP risk				
	assessment and co					
	- policy and proced	ure addressing whether				
	evacuated or shelte	er in place for staff/residents				
	for food, water, med	dical supplies, pharmaceutical				
	supplies;					
		ure addressing alternate				
		o maintain temperatures to				
		alth/safety, safe and sanitary				
		ns emergency lighting and				
	sewage and waste					
		ure for a system to track the staff and sheltered residents				
	,	and sheltered residents are				
		y must document the specific				
		e receiving facility or other				
	location;	o receiving racinity of earler				
		ure addressing safe				
		cility, including care and				
	treatment needs of					
		nary/alternate communication				
	means with externa	al sources of assistance;				
		ure to shelter in place for				
		d volunteers who remain in the				
	facility;					
		ure addressing system of				
		ation that preserves resident				
	information, protect	s confidentiality, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30630	B. WING		09/1	2/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH				
	AUSTIN, N	//N 55912			
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 680 Continued From pag	je 42	0 680			
secures/maintains at policy and procedu volunteers, including integration; policy and procedu of arrangements with receive residents in a limitations/cessation continuity of services policy and procedu facility under waiver accordance with sec develop a written or communication pla names/contact inform providing services un physicians, other fact communication pla information for Fede local EP staff; State Agency; MN Office of other sources of ass communication pla alternate means of contact information pla alternate means of contact information pla staff and Federal, Staff and Federal and Feder	availability of records; are addressing use of gothe process/role for ares addressing development the other facilities/providers to the event of a of operations to maintain the sto residents; are addressing the role of declared by the Secretary in ction 1135 of the ACT; communication plan; an which includes mation: staff, entities ander agreement, residents' cilities, volunteers; an which includes contact eral, State, tribal, regional and Licensing and Certification of Ombudsman for LTC and sistance; an which includes primary and communication with facility tate, tribal, regional and local ment agencies; an which includes method for and medical documentation the facility's care, as er health care personnel to of care; means, in event of se resident information as CFR 164.510(b)(1)(ii); means	0 680			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
0 680	Continued From pa	ge 43	0 680			
0 680	command center, of communication plasharing information that the facility has residents and their cevelop and main program; training program of EP policy and procestaff, individuals programed arrangement, volunt expected role; provannually; maintain of training; demonstrationally; maintain of training; demonstrationally; maintain of training; demonstrationally based functionally based functionally based functionally based functionally based functionally based or an individual exercise or mock dexercise; if part of a health of separately certified have a unified and choose to participate and integrated and integrated and integrated the system actively development of the	or designee; and an which includes method for from the emergency plan, determined appropriate, with families/representatives; tain an EP training and testing which includes initial training in edure to all new and existing oviding services under iteers consistent with their ide EP training at least documentation of all EP ite staff knowledge of EP; is to test EP at least twice per innounced staff drills using EP, ing in an annual full-scale by based or annual individual onal exercise or if facility ual emergency requiring facility is exempt form a required full scale exercise; and annual exercise that may all scale exercise community ual; facility based functional isaster drill or table top care system consisting of healthcare facilities elects to integrated EPP, they may the and if elected demonstrate retified within the system d in the development of the ed EPP. If elected the EPP each separately certified within participated in the unified and integrated EPP,	0 680			
	the system actively development of the including developin	participated in the unified and integrated EPP, g/maintaining in a manner that each separately certified				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
0 680	each separately ceractively using the uncompliance with the unified/integrated Eincluding document assessment, utilizing documented individual assessment for each within the health synapproach and inclumented individual assessment for each within the health synapproach and inclumented individual assessment for each within the health synapproach and inclumented inclumented in the procedure that meet on September 7, 2 stated, "I don't have plan." LALD-A state compliance director stated the only information was the Emergency January 7, 2017. Lealls about Appendice about Appendice and Appendix Z. LALD-everything in place assessment."	ervices offered; demonstrate rtified facility is capable of nified/integrated EPP and in in	0 680			
0 730 SS=E	Contents of a reside following for each re (1) identifying inform	ontents of resident record ent record include the esident: mation, including the resident's , address, and telephone	0 730			

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	ita Department of He		1			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AIND LEWIN	OI CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		CONIP	LLILD
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10 10 1	TO VIDER OR GOLF EIER	204 14TH		517 W.E., Ell. 00BE		
KSMS OUR HOUSELLC			MN 55912			
040.15	CUMMADY CTA	<u> </u>		DDOV/DEDIC DLAN OF CODDECT/	DNI .	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 730	Continued From page 45		0 730			
0.730	(2) the name, address the resident's emer representatives, an (3) names, address the resident's health providers, if known; (4) health informatic allergies, and when medications, treatm documentation, and records; (5) the resident's ac (6) copies of any he guardianships, pow conservatorships; (7) the facility's curr assessments and s (8) all records of coresident's services; (9) documentation or resident's status and the needs of the resident's status and the needs of the resident and actions needs of the resident needs need	ess, and telephone number of gency contact, legal d designated representative; ses, and telephone numbers of an and medical service on, including medical history, the provider is managing ments or therapies that require d other relevant health dvance directives, if any; ealth care directives, ears of attorney, or tent and previous service plans; mmunications pertinent to the directions taken in response to sident, including reporting to service or health care of incidents involving the staken in response to the int, including reporting to the sor or health care that services have been ed in the service plan; at that the resident has received essisted living bill of rights; a of complaints received and immary, including service				
	when applicable; ar	and related documentation, nd ntation required under this				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 730	Continued From pa	ge 46	0 730			
	chapter and relevant to the resident's services or status.					
	by: Based on interview licensee failed to en included a discharge content and provide facility as required fresident (R3). In additional ensure required contents (R2).  This practice result violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number.	and record review, the asure the resident record le summary with the required ed information to the receiving for one of one discharged dition, the licensee failed to a level two violation (a tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a residents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	include: - diagnoses; - course of illness; - allergies; - treatments and the - pertinent lab, radio and - a final summary o latest assessment	erapies; blogy, and consultation results; f the resident's status from the or review including baseline, behavioral, and functional				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
KSMS O	UR HOUSE LLC	204 14TH				
AUSTIN, I			/N 55912			
(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
0 730	Continued From pa	ge 47	0 730			
	evidence of providir writing to the receiv - the name and address of the resident's add the name and address or community contatto the facility; - the resident has refacility; and - the resident's currand "physician order if any.	sses of any significant social acts the resident has identified at recent service or care plan, eceived services from the ent "do not resuscitate" order or for life-sustaining treatment,"				
		services on December 2, harged on April 11, 2022. R3's dementia.				
	R3 was discharged another care facility sent with. The medibelongings were tal attorney) and the Pat the other facility. minimal assist with ambulation and trar	dated April 11, 2022, indicated from facility at 8:00 a.m. to a for men. All medications were ication log was filled out. All ken by "POA" (power of OA was going to meet resident Upon discharge resident was toileting, independent with insfers, reminders with endent with eating at all				
	2021, through April had behaviors inclu taking other resider relationship with a f	s dated from November 1, 11, 2022, further indicated R3 ding increased agitation, nts' food at meal times, emale resident, taking paper them down sink drain and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	1 03/1	ZIZUZZ
		204 14TH		STATE, ZIF GODE		
KSMS O	UR HOUSE LLC		MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 730	Continued From pa	ige 48	0 730			
	attempting to clog t	oilet, and sexual urges.				
	physician progress R2's Service Plan i	ntegrated into R2's 90-day				
	service plan indicat included p.m. snac check, bathing, bow C-collar (neck brac compassionate tou environmental assis assist/supervise, fa assistance, hearing housekeeping, reco	Il risk monitoring, grooming g aid/glasses assistance, ord intake snacks, mobility and				
	walking assistance, medication management, mobility equipment check, skin care treatment, toileting assistance, supervision for safety/wandering/elopement, wellness monitoring/treatment, behavior monitoring and indicated for skin care treatment May 27, 2022, resident noted to have an old healing blister on top of right big toe. "Area will be observed daily and Band-Aid will be applied for protection. Toe guard to right toe will be held due to area until					
	healed." The service for the service of easpiration precaution Resident is to rema eating. R2's service services of C-collars.	e plan/assessment indicated ating assistance resident is in on and mechanical soft diet. ain upright 30 minutes after a plan lacked the treatment to to guards to right and left and mechanical soft diet.				
	September 2022, ir C-collar staff are to C-collar on at all tin	ration Record dated ndicated the same and for ensure that the resident has nes. Please document here if C-collar. Has foam collar to				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH						
		MN 55912	DD OVERTING DI AN OF CORRECTIO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 730	Continued From pa	ge 49	0 730			
	change into when to	aking a shower.				
	personnel (ULP)-E medications to R2 a right and left great to Consequence of the staff were R2 was given "Ensure "Ensure Push Ensure." A was not sure if R2 word. ULP-D stated Fit texture diet and "mobetter."  R2's record lacked health information, other relevant health	022, at 9:28 a.m. ULP-D e monitoring R2's intake and ure supplement. If not eating at 9:32 a.m., ULP-D stated she was to be wearing C-collar or R2 was on a "mechanical soft neat was shredded, swallows  documented evidence of including medical history and th records due to the licensee nent of medication and				
	nurse (RN)-B confir expedited termination stated the progress was the only documed discharge summary the nurse had a correferring to the facilito. RN-B stated the documentation in winformation was program.	022, at 11:29 a.m. registered rmed the licensee had on of services for R3. RN-B is note dated April 11, 2021, mented information of y for R3. RN-B stated, "I known versation with facility staff", lity R3 was being discharged licensee had no writing regarding what by				
	No further informati	on was provided.				
	TIME PERIOD FOR	R CORRECTIONS:				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING	B. WING		2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
0(0) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	MN 55912	DDOVIDEDIS DI AN OF CORDECTION	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
0 730	Continued From pa	ge 50	0 730			
	Twenty-one (21) da	ys				
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment		0 800			
	(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.					
	This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff and visitors.					
	This practice resulted in a level two violation ( a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope ( when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).					
	The findings include	e:				
	2:00 PM, survey sta LALD-A. During the	n approximately 12:30 PM to aff toured the facility with a facility tour, survey staff ccumulation of lint debris				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOSED TO THE APPROPOSED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
0 800	Continued From pa	ge 51	0 800			
	LALD-A verbally columns observation during	he facility tour.				
	No further informati TIME PERIOD FOF (21) days	on provided.				
0 930 SS=C	144G.50 Subd. 2 (d	-e; 1-4) Contract information	0 930			
	facility's complaint residents, including information of the p who is designated to complaints.  (e) The contract muconspicuous notice (1) the right under stermination of an as (2) the facility's polic residents within the circumstances a tracircumstances under equired for a transi (3) contact informat Ombudsman for Lo Ombudsman for McDevelopmental Disa Health Facility Com (4) the resident's rigunaffiliated service  This MN Requirements by:  Based on interview licensee failed to expend the property of the policy of the policy.	ection 144G.54 to appeal the sisted living contract; by regarding transfer of facility, under what insfer may occur, and the er which resident consent is fer; ion for the Office of ing-Term Care, the ental Health and abilities, and the Office of plaints; iht to obtain services from an				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER	204 14TH	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 930	This practice resulted violation that has not a minimal impact or affect health or safe widespread scope (or represent a system or has potential to a the residents).  The findings included R2's Resident and 3 was signed by licent on October 6, 2021 representative on CR1's Residence and signed was signed and October 7, 202 representative.  R2 and R1's Residence and signed was signed was signed and October 7, 202 representative.  R2 and R1's Reside indicated on page to director of our house for ensuring that an a satisfactorily and maintain an open of family (if resident so participation) to expending the fact of the name and contract representing the fact handle and resolve.  On September 12, 2	ed in a level one violation (a potential to cause more than in the resident and does not ety), and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of etc.  Service Agreement (contract) sed practical nurse (LPN)-G, and R2's resident legal october 27, 2021.  It describes Agreement was by LPN-G on October 6, 2021, 1, by R1's resident  ent and Service Agreement welve (12), "The executive sing senior living is responsible by complaints are addressed in timely manner and will oor policy for all residents and ochooses family member's press any concerns."  ent and Service Agreement grequired content: act information of the person cility who is designated to	0 930			

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW MN 55912			
	0.18.44.57.4.074			DE OVERERO DI ANI OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 930	Continued From pa	ge 53	0 930			
	requirement, LALD verified the licenses	the missing contract -A responded, "ok". LALD-A e's Resident and Service ized for all residents.				
	TIME PERIOD FOR Twenty-One (21) da	R CORRECTION:				
0 940 SS=C	144G.50 Subd. 2 (e	e; 5-7) Contract information	0 940			
	medical assistance and section 256B.4 program under cha (i) whether the facil commissioner of hucustomized living sassistance waivers (ii) whether the faci provide housing su subdivision 2, paraguilli) whether there is people residing at the customized living su housing support proso, the limit must be (iv) whether the faci privately for a periodic payment under mechousing support protime that private paraguilli (v) a statement that provide payment for the cost of rent; (vi) a statement that	lity has an agreement to pport under section 256I.04, graph (b); s a limit on the number of he facility who can receive ervices or participate in the ogram at any point in time. If e provided; ility requires a resident to pay d of time prior to accepting dical assistance waivers or the ogram, and if so, the length of				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS OU	R HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	people who are elig waivers but who are through the housing (6) the contact inforcare consulting servers 256B.0911; and (7) the toll-free photo Adult Abuse Report This MN Requirements by: Based on interview licensee failed to exthe required contents (1).  This practice results violation that has not a minimal impact of affect health or safe widespread scope (or represent a system or a potential to a the residents).  The findings include R2's Resident and was signed by licenton October 6, 2021 representative on CR1's Residence and signed was signed and October 7, 202 resident/representative R2 and R1's Residence and R2 and R1's Residence and R2 and R1's Residence R2 and R1's R2	If the rent requirements for public for medical assistance is not eligible for assistance is support program; mation to obtain long-term vices under section one number for the Minnesotating Center.  The tis not met as evidenced and record review, the secute a written contract with the for two of two residents (R2, and the resident and does not easy), and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of the secute and R2's resident legal october 27, 2021.  If Services Agreement was by LPN-G on October 6, 2021, 1, by R1's	0 940			

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Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS C	OUR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 940	Assistance Waivers Programs. The con medical assistance programs is et forth "Exhibit 5" indicated the following State and assistance and Elder waiver, communiclusion and House as Group Resident R2 and R1's Residulacked the following whether the facility commissioner of he customized living seasistance waivers whether the facility privately for a perioderical payment under methousing support protime that private parassistance with reners assistance with reners assistance with reners assistance with reners and a description of the who are eligible for but who are not eligible for but who ar	s and Housing Support inpany's policy regarding waivers and housing support in Exhibit 5 attached hereto." If the licensee was "enrolled in of Minnesota Medicaid waiver I housing support programs: nunity Access for Disability ing Support (formerly known ial Housing).  The tent and Service Agreements grequired content: is enrolled with the uman services to provide ervices under medical is requires a resident to pay d of time prior to accepting dical assistance waivers or the ogram, and if so, the length of yment is required; esidents may be eligible for t through the housing support are rent requirements for people medical assistance waivers gible for assistance through the	0 940			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 940	Continued From pa	ge 56	0 940			
	we would not get pa	aid."				
	No further informati	on was provided.				
	TIME PERIOD FOF Twenty-One (21) da					
0 950	144.50 Subd. 3 Des	signation of representative	0 950			
SS=C	assisted living contr must offer the resid a designated repres contract and must p notice on a docume "RIGHT TO DESIG FOR CERTAIN PUI You have the right to "Designated Repres	time of execution of an ract, an assisted living facility ent the opportunity to identify sentative in writing in the provide the following verbatiment separate from the contract:  NATE A REPRESENTATIVE RPOSES.  o name anyone as your sentative." A Designated assist you, receive certain				
	information and not some information re advocate on your be Representative doe guardian, conserva ("attorney-in-fact"),	ices about you, including elated to your health care, and				
	the name and conta designated represe must initial if the res designated represe subdivision 1, parag- right at any time to	ast contain a page or space for act information of the ntative and a box the resident sident declines to name a ntative. Notwithstanding graph (f), the resident has the add, remove, or change the nformation of the designated				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.	
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 950	Continued From pa	ge 57	0 950			
	by: Based on interview licensee failed to en the required notice representative on a contract and failed included required c residents (R2, R1). This practice result	and record review, the assure the licensee provided for right to designated document separate from the to ensure the contract ontent for two for two				
	a minimal impact of affect health or safe widespread scope or represent a syste	o potential to cause more than in the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of				
	The findings include	e:				
	was signed by licer	Service Agreement (contract) used practical nurse (LPN)-G, and R2's resident legal october 27, 2021.				
	signed by LPN-G o	d Services Agreement was n October 6, 2021, and R1's e party on October 7, 2021.				
	Services Agreemer "RIGHT TO DESIG FOR CERTAIN PU to name anyone as Representative." A can assist you, rece	2 and R1's Residence and at contained verbatim notice of NATE A REPRESENTATIVE RPOSES. You have the right your "Designated Designated Representative eive certain information and including some information				

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Millineso	ta Department of He	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
		204 14TH				
KSMS O	UR HOUSE LLC	AUSTIN, N				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
0 950	Continued From pa		0 950			
		th care, and advocate on your				
		ed Representative does not				
		our guardian, conservator,				
		'attorney-in-fact"), or health ney ("health care agent"), if				
		ge seventeen (17) of the				
		vices Agreement included the				
		ce with an area for the				
	designated resident	t to be listed; however, R2 and				
		d evidence in writing of				
		tim notice on a document				
	separate from the o	contact as required.				
		R1's Resident and Service				
	•	the required box the resident sident declines to name a				
		ntative as part of the contract				
	as required.	ritative de part of the contract				
	'					
	•	2022, at approximately 10:00				
		ted living director (LALD)-A				
		ling the missing information				
		-A verified the licensee's ce Agreement was utilized for				
	all residents.	ce Agreement was utilized for				
	an residents.					
	No further informati	on was provided.				
	TIME PERIOD FOR	R CORRECTION: Twenty-One				
	(21) days					
	· •					
0 970 SS=F	144.50 Subd. 5 Wa	ivers of liability prohibited	0 970			
33-6	The contract must a	not include a waiver of facility				
		not include a waiver of facility h and safety or personal				
		ent. The contract must not				
		on that the facility knows or				
		deceptive, unlawful, or				
		er state or federal law, nor				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: CO	TE SURVEY MPLETED
30630 B. WING 09	/12/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
KSMS OUR HOUSE LLC 204 14TH ST NW AUSTIN, MN 55912	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY DEFICIENCY DEFICIENCY)	(X5) COMPLETE DATE
o 970  Continued From page 59  include any provision that requires or implies a lesser standard of care or responsibility than is required by law.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 17 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 included:  R2's Residence and Service Agreement (contract) was signed by licensed practical nurse (LPN)-G on October 6, 2021, and R2's resident legal representative on October 27, 2021.  R1's Residence and Services Agreement was signed by LPN-G on October 6, 2021, and R1's resident responsible party on October 7, 2021.  The Residence and Services Agreement included on page eleven (11) the following:  "D. Responsibility for your property, We strongly recommend that you maintain at all times your own insurance coverage, including health, personal property, liability and automobile (if	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	STREET ADI 204 14TH AUSTIN, N	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 970	are not responsible personal property be fire, or any other can damage was cause employees' gross in -"E. Responsibility for others. You are responsible to persons acts or negligence. Hold harmless the coloss, cost or damage any person or property our acts or negligerer. Act of other responsible to your another resident that or damage to your attempt and the responsibility for your property arisin or negligence of oth action of any employed.  On September 12, a.m. licensed assis confirmed the license.	es in adequate amounts. We for any damage or loss of any relonging to you due to theft, ruse, unless the loss or ed by our community regligence." For damages or injury to ponsible for any injury or or property caused by your You agree to indemnify and community from all liability, ge for any injury or damage enty arising from or caused by ence."  Sidents. The community is not for any acts or negligence of at may result in injury, illness or your property. By signing a release the community from injury or damage to you or g from or caused by the acts her residents or from the oyee or any provider."  2022, at approximately 10:00 ted living director (LALD)-A see's Residence and Services esidents included the above	0 970			
0 990 SS=D	contract	rerequisite to termination of a	0 990			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 990	assisted living contrand participate in a the resident's legal representative. The to:  (1) explain in detail termination; and (2) identify and offe or modifications, into avoid the termination remain in the facility securing services for resident's choosing avoid the termination offer accommodation interventions, or alto alter the nature of the folion of the participate in the modern of the participate in the participate in the modern of the participate in	ract, a facility must schedule meeting with the resident and representative and designated purposes of the meeting are the reasons for the proposed reasonable accommodations reventions, or alternatives to on or enable the resident to on another provider of the that may allow the resident to one. A facility is not required to one, modifications, rematives that fundamentally ne operation of the facility. It is the scheduled to take place before a notice of termination ty must make reasonable at the resident, legal designated representative are neeting. It notify the resident that the family members, relevant is, a representative of the lan for Long-Term Care, or resident's choosing to resident's choosing to remust notify the resident's	0 990			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION		E SURVEY PLETED
	30630	B. WING		09/	12/2022
NAME OF PROVIDER OR SUPPLI	ER STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
by: Based on intervir licensee failed to meeting with a re Ombudsman for a termination of (R3).  This practice resviolation that did safety but had the resident's health widespread scop or represent a syor has the potent of the residents).  The findings includes a scheduled representative at sent a scheduled the Office of Omprior to expedited living contract.  R3 began received 2020, and was diagnoses included R3's expedited to contract dated Malicensee's "admisengaged in condwith the rights, here	ew and record review, the ensure the opportunity of a expresentative of the Office of Long-Term Care before issuing services for one of one resident culted in a level two violation (a not harm a resident's health or expotential to have harmed a or safety), and was issued at a expressive extemic failure that has affected ital to affect a large portion or all cude:  The documented evidence the R3, and the resident's legal and designated representative of budsman for Long-Term Care at termination of R3's assisted on Services on December 2, ischarged on April 11, 2022. R3's				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
		204 14TH	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE
0 990	PROVIDER OR SUPPLIER  204 14TH AUSTIN, N  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63  Upon admission to the location, inappropriate sexual behaviors were not observed or noted. However, in the past, you have exhibited inappropriate sexual behaviors. At this time, it is felt that the amount of care you require is more care than we can sufficiently and safely staff at the location and your care is beyond minimal care and you have been deemed as no longer appropriate for the client group at this memory care. It is felt that at this time that you would be more appropriately placed at a location that has more staffing needs." The termination notice indicated "per conversation with the resident's POA [power of attorney] and case worker an expedited termination of assisted living contract meeting was declined."  On September 8, 2022, at 11:29 a.m. registered nurse (RN)-B confirmed the licensee had expedited termination of services for R3. RN-B stated, I was not the discharging nurse. I can't answer that," regarding if the licensee offered R3 and the resident's legal representative and designated representative sent with a representative of the Office of Ombudsman for Long-Term Care prior to expedited termination of R3's assisted living contract.  No further information was provided.  TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days		0 990			
01030 SS=D	144G.52 Subd. 6 R	ight to use provider of	01030			
	contract if the unde	rlying reason for termination				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
01030	services from anoth choosing and the restriction of the restriction of the resident (R3).  This practice results violation that did not safety but had the president's health or cause serious injury was issued at an issilimited number of real limited number of real limited number of situation has occurred. The findings included R3's record lacked licensee attempted reason for termination another provider of the resident obtains terminating the assemble R3 began receiving 2020, and was discondingnoses included R3's expedited termination conductions and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains terminating the assemble R3's expedited terminations and the resident obtains the resident	ner provider of the resident's esident obtains those services.  ent is not met as evidenced and record review, the ddress if services form another uld be obtained to prevent ces for one of one discharged ed in a level two violation (a tharm a resident's health or obtained to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a staff are involved or the red only occasionally).  e:  documented evidence the to resolve the underlying ion by obtaining services from the resident's choosing and a those services, prior to isted living contract.  services on December 2, harged on April 11, 2022. R3's	01030			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	12/2022
NAME OF PROVIDER OR SI	UPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS OUR HOUSE LI	LC	204 14TH AUSTIN, I	ST NW MN 55912			
PREFIX (EACH DE	EFICIENC'	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
sexual behar However, in inappropriate felt that the care than we the location and you have appropriate care. It is fee more appropriate care. It is fee more appropriate care staffin.  R3's progress was dischar another care sent with. Moreover, was dischar another care sent with. Moreover, and the other minimal assonal and the other minimal assonal and the same als.  R3's progress 2021, through ad behavior taking other consensual (#16), taking sink drain as sexual urges.  R3's record specifics regnoted above	ssion to aviors we the past amount e can se and your e been for the lt that a priately generated the Properties were tand the Properties with and trained independent of the properties inclusively and the properties inclusively and the properties inclusively and the properties inclusively and attention of the properties toward lacked garding e in the	the location inappropriate ere not observed or noted. st, you have exhibited all behaviors. At this time, it is to of care you require is more sufficiently and safely staff at the care is beyond minimal care deemed as no longer client group at this memory this time that you would be placed at a location that has st."  dated April 11, 2022, indicated m facility at 8:00 a.m. to for men. All medications were on log was filled out. All ken by "POA" (power of OA was going to meet resident Upon discharge resident was toileting, independent with endent with eating at all stated from November 1, 11, 2022, further indicated R3 iding increased agitation, ints' food at meal times, iship with a female resident towels and putting them down inpting to clog toilet, and	01030			

Minnesota Department of Health

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Minnesota Department of Health						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LLIED
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
V0M0 0	UD HOUGE LLO	204 14TH	ST NW			
KSWS U	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAO		,	IAG	DEFICIENCY)		
01030	Continued From pa	nge 66	01030			
01000	•		01000			
		deemed as no longer				
		client group at this memory t this time that you would be				
		placed at a location that has				
		s" the licensee could not meet				
		another care provider would				
		's needs before termination of				
		contract or documented				
	evidence of what the licensee attempted for resolution before termination of the assisted living					
	contract.	Timilation of the addicted living				
		022, at 11:29 a.m. registered				
		rmed the licensee had				
		on of services for R3. RN-B harged to a men's only facility.				
		d a female resident move over				
		because of safety issue. RN-B				
		ventions in place, but they did				
		ted we did ask R3's case				
		services were available. RN-B robably emails regarding				
		ne case worker about other				
		however, no other information				
	was provided.	•				
	The Press of At	Waste a Davidson Division				
		itoring Resident Discharges				
		mber 2021, indicated together rof operations and director				
		ideas to keep the resident				
	with facility if appropriate. Daily the director					
		ng resident concerns, including				
		ent altercations, with the				
		operations. Both the regional				
		ns and the director should tions that need to take place				
		ate the behavior or concern.				
	TIME PERIOD FOR	R CORRECTIONS:				

6899

Minnesc	<u>ota Department of He</u>	alth				
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01030	Continued From pa	ge 67	01030			
	Twenty-one (21) days					
01040 SS=D	0 144G.52 Subd. 7 Notice of contract termination required		01040			
	written notice of tensection. The facility termination notice to for Long-Term Care receive home and conservices under chap 256B.49, to the resident. A facility more resident of the legal representative representative.  (c) A facility termination notice at legal representative representative.  (c) A facility termination of the legal representative representative.  (d) If a resident more resident more resident any notice at least 15 days the resident any notice at least notice at least 15 days the resident any notice received from the resident any notice received and the resident any notice at least not the resident any notice received from the resident any notice at least not not the resident any notice at least not not not not not not not not not no	nd 5. ating a contract under nust provide a written at least 30 days before the e termination to the resident, e, and designated ating a contract under provide a written termination ays before the effective date of				
	by: Based on interview	ent is not met as evidenced and record review, the end a copy of the termination				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
1101110 0	OK HOUSE EES	AUSTIN, N	IN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01040	notice to the Office Care for one of one This practice results violation that did no safety but had the president's health or widespread scope (or represent a syste or has the potential of the residents).  The findings include R3's record lacked copy of R3's expedi Office of Ombudsm R3 began receiving 2020, and was disc R3's diagnoses include R3's expedited term contract dated Marc licensee, "admissio engaged in conduct with the rights, heal of the community (in Upon admission to sexual behaviors we However, in the pasinappropriate sexual felt that the amount care than we can set the location and you and you have been appropriate for the care. It is felt that at	of Ombudsman for Long-Term resident (R3).  ed in a level two violation (a tharm a resident's health or votential to have harmed a safety), and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all existence on December 2, harged on April 11, 2022. Unded dementia.  Inination of assisted living that 24, 2022, indicated per the in agreement the resident has a that substantially interferes that substantially interferes that of safety of other residents inappropriate sexual behavior). The location inappropriate ere not observed or noted. St, you have exhibited all behaviors. At this time, it is of care you require is more ufficiently and safely staff at air care is beyond minimal care deemed as no longer client group at this memory is this time that you would be	01040			
	care. It is felt that at	this time that you would be placed at a location that has				

6899

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				D. WING		
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
AUSTIN,			MN 55912			,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01040	Continued From page 69		01040			
	nurse (RN)-B confir expedited termination stated she would lo information if R3's e was sent to the Offi	expedited termination notice ce of Ombudsman for owever, no information was				
	Twenty-one (21) da					
01050 SS=F	144G.52 Subd. 8 C	ontent of notice of termination	01050			
	The notice required under subdivision 7 must contain, at a minimum:  (1) the effective date of the termination of the assisted living contract;  (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;  (3) a detailed explanation of the conditions under which a new or amended contract may be					
	executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;					
		ow to contact the Office of ng-Term Care to request an				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	I ST NW MN 55912			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01050	(8) information on halinkAge Line under 7, and an explanation of the line may provide in available housing of (9) if the termination statement that the facility and may see from another provide and the facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and may see from another provide and the line facility and the l	regarding the termination; now to contact the Senior r section 256.975, subdivision on that the Senior LinkAge of service options; and is only for services, a resident may remain in the cure any necessary services der of the resident's choosing.  ent is not met as evidenced and record review, the facility termination notice which red information for one of one ded in a level one violation (a potential to cause more than in the resident and does not ety) and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of esservices on December 2, charged on April 11, 2022.				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING	B. WING		2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		Ì
KSMS O	UR HOUSE LLC	204 14TH				
(V4) ID	SLIMMARY STA	AUSTIN, N TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	- N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
01050	Continued From page 71		01050			
	admission to the local behaviors were not in the past, you have sexual behaviors. A amount of care you can sufficiently and your care is beyond been deemed as not client group at this time that you we placed at a location needs."	opriate sexual behavior). Upon cation, inappropriate sexual observed or noted. However, we exhibited inappropriate at this time, it is felt that the require is more care than we safely staff at the location and minimal care and you have to longer appropriate for the memory care. It is felt that at ould be more appropriately that has more staffing				
	which a new or ame executed; - a statement that the appeal the terminate and information consumption which the request in contact information request must be sureduced in the statement that the coordinated move to caregiver, as requireduced to the name and consumption on how of the statement that the name and consumption on how of the statement that the name and consumption on how of the statement that the name and consumption on how of the statement that the name and consumption on how of the statement that the statement that the statement that the statement that the name and consumption on how of the statement that the statement t	ne facility must participate in a o another provider or ed under section 144G.55; tact information of the person cility with whom the resident				

Minnesota Department of Health

ota Department of He					
NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
	30630	B. WING		09/1	2/2022
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			,		
UR HOUSE LLC					
SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
		PREFIX			COMPLETE DATE
REGULATORY OR L	SCIDENTIFTING INFORMATION)	IAG	DEFICIENCY)	PRIATE	DAIL
			<u> </u>		
Continued From pa	ge 72	01050			
stated, "We are lea	rning the process yet."				
No further informati	ion was provided				
NO IUITII II	on was provided.				
TIME PERIOD FOR	R CORRECTIONS:				
	•				
01370 144G.61 Subd. 2 (a) Training and evaluation of		01370			
· 					
   , , <del>_</del>					
` '	equilements for all services				
	ses in the resident's condition				
pathogens;	-				
\ <i>\</i>	a clean and safe				
	ino, and oral prostnetto				
•	hearing aids; and				
	nce techniques and how to				
	rcise, and treatment				
,	mod proporation food acfaty				
	PROVIDER OR SUPPLIER  UR HOUSE LLC  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  On September 8, 2: nurse (RN)-B verific document lacked the stated, "We are lea  No further informati  TIME PERIOD FOR Twenty-one (21) da  144G.61 Subd. 2 (a unlicensed personne  (a) Training and con unlicensed personne  (1) documentation in provided; (2) reports of change to the supervisor de (3) basic infection of pathogens; (4) maintenance of environment; (5) appropriate and hygiene and groom (i) hair care and base (ii) care of teeth, guidevices; (iii) care and use of (iv) dressing and as (6) training on the perform them; (8) medication, exe reminders; (9) basic nutrition, r and assistance with	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  30630  PROVIDER OR SUPPLIER  STREET AD  204 14TH AUSTIN, I  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  On September 8, 2022, at 11:29 a.m. registered nurse (RN)-B verified the R3's termination notice document lacked the above content. RN-B stated, "We are learning the process yet."  No further information was provided.  TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days  144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn  (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	IT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER STREET ADDRESS, CITY, SOME AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  On September 8, 2022, at 11:29 a.m. registered nurse (RN)-B verified the R3's termination notice document lacked the above content. RN-B stated, "We are learning the process yet."  No further information was provided.  TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days  144G.61 Subd. 2 (a) Training and evaluation of unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	IT OF DEFICIENCIES OF CORRECTION  IDENTIFICATION NUMBER: 30630  STREET ADDRESS. CITY, STATE, ZIP CODE  WING  ROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  244 14TH ST NW AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  On September 8, 2022, at 11:29 a.m. registered nurse (RN)-B verified the R3's termination notice document lacked the above content. RN-B stated, "We are learning the process yet."  No further information was provided.  TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days  144G.61 Subd. 2 (a) Training and evaluation of unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	IT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER NUMBER:  30630  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72  On September 8, 2022, at 11:29 a.m. registered durse (RN)-B verified the R3's termination notice document lacked the above content. RN-B stated, "We are learning the process yet."  No further information was provided.  TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days  144G.61 Subd. 2 (a) Training and evaluation of unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility: (3) basic infection control, including: (6) training and grooming, including: (6) and grooming, including: (7) standby agrounds, and grooming, including: (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (9) assis under sating; (9) assis under sati

Minnesota Department of Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30630	B. WING		09/12/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	-NOVIDEN ON SUFFEIEN	204 14TH		STATE, ZIF GODE		
KSMS O	UR HOUSE LLC	AUSTIN, N	_			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
01370	Continued From pa	ge 73	01370			
	licensed health prof	fessional;				
		skills that include preserving				
		sident and showing respect for				
	the resident and the	e resident's preferences,				
	cultural background					
		confidentiality and privacy;				
		appropriate boundaries				
		esidents and the resident's				
	family;	use in handling vericus				
	emergency situation	use in handling various				
		commonly used health				
		ent and assistive devices.				
	toomiology oquipmi	on and acciding acvices.				
	This MN Requireme	ent is not met as evidenced				
	by:					
		on, interview and record				
		e failed to ensure training and				
		tions contained all the				
		two of two unlicensed				
	personnel (ULP-E,	ULP-F).				
	This practice result	ed in a level two violation (a				
		t harm a resident's health or				
		ootential to have harmed a				
		safety, but was not likely to				
		y, impairment, or death) and				
		tern scope (when more than a				
		esidents are affected, more				
		per of staff are involved, or the				
		red repeatedly; but is not				
	found to be pervasi	ve).				
	The findings include	ə:				
	ULP-E had a hire d	ate of May 11, 2022. ULP-E				
		e and services to the licensee				
	residents.					
	On September 7, 2	022, at 8:13 a.m. ULP-E was				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH				
		AUSTIN, N	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01370	Continued From pa	ge 74	01370			
	observed to administer medications to R2 and applied toe guards to R2's right and left great toes.					
	completed training of a coumentation required provided; -reports of changes the supervisor designation and treat and satisfies the supervisor designation and groom (i) hair care and bat (ii) care of teeth, guidevices; (iii) care and use of (iv) dressing and astraining on the prevestandby assistance perform them; -exercise, and treat communication skill dignity of the resider resident and the resider.	uirements for all services in the resident's condition to gnated by the facility; clean and safe environment; fe techniques in personal ing, including: thing; ms, and oral prosthetic hearing aids; and esisting with toileting; vention of falls; etechniques and how to ment reminders; lls that include preserving the nt and showing respect for the sident's preferences, cultural				
	background, and family;  ULP-E's record lacked documentation of completed competency for the following: -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -standby assistance techniques and how to perform them					

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ULP-F had a hire date of August 11, 2022. ULP-F

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIF	LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		204 14TH	, ,	,		
KSMS O	UR HOUSE LLC		MN 55912			
(VA) ID	QI IMMA DV QTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	<u></u>	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
01370	Continued From pa	ge 75	01370			
	provided direct care residents.	e and services to the licensee				
		ked documentation of				
	completed training					
		uirements for all services				
	provided;	in the resident's condition to				
		gnated by the facility;				
	<ul> <li>-maintenance of a clean and safe environment;</li> <li>-standby assistance techniques and how to perform them;</li> </ul>					
	-exercise, and treat					
		lls that include preserving the				
		nt and showing respect for the				
		sident's preferences, cultural				
	background, and fa					
		monly used health technology				
	equipment and ass	istive devices.				
	On September 12.	2022, at approximately 9:47				
		se (RN)-B verified ULP-E and				
	ULP-F lacked the re					
	demonstrated skill of	competency by an RN for the				
		3 stated licensed practical				
		competency evaluated ULP-E				
		competency evaluation. It				
	was not completed	by a RN as required.				
	No further informati	on provided.				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				
	(21) days					
	(//-					
01380	144G.61 Subd 2 (h	) Training and evaluation of	01380			
SS=D	unlicensed personn					
	(b) In addition to pa	ragraph (a), training and				
		tion for unlicensed personnel				

Minneso	ta Department of He		T		1	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01380	Continued From pa	ge 76	01380			
	(1) observing, reporesident status; (2) basic knowledge changes in body further observed changes appropriate person (3) reading and recand respirations of (4) recognizing phy and developmental (5) safe transfer tec (6) range of motion (7) administering management of the motion (7) administering management of the motion (8) and the motion (9) administering management of the motion (10) administering management of the motion (11) administering management of the motion (12) administering management of the motion (13) administering management of the motion (13) and the motion (13) administering management of the motion (13) and the motion (13) administering management of the motion (13) and the motion	ording temperature, pulse,				
	This practice result violation that did no safety but had the president's health or cause serious injury was issued at an is limited number of real limited number of	ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or is staff are involved or the red only occasionally).				
	ULP-E had a hire d	ate of May 11, 2022. ULP-E e and services to the licensee				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01380	Continued From pa	ge 77	01380			
		022, at approximately 1:00 served to check R1's blood				
	completed training	ked documentation of for the following: g, and documenting resident				
	completed competer reading and record respirations of the resafe transfer technical respirations.	iques and ambulation; and positioning; and				
	documented by lice on July 27, 2022, for airway pressure), ca testing, oxygen satu compression stocki ULP-E's record lack	uded competency training insed practical nurse (LPN)-Gor CPAP (continuous positive atheter care, blood glucose furation (O2 SATS), oxygen, ings and ace wrap; however, ked documented competency se (RN) for the treatments as				
	a.m. RN-B verified training and demon the above topics. R competency evalua	2022, at approximately 9:47 ULP-E lacked the required strated skill competency for N-B stated LPN-G had ted ULP-E for topics requiring tion, but not by a RN as				
	Medication Manage Policy dated June 2 ensure unlicensed	nesota Delegation of ement and Treatment Services 2020, indicated the RN would personnel were trained, entated to the resident				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		30630	B. WING		09/1	09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.1		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
01380	treatment manager A RN may delegate unlicensed team methat the unlicensed competent and had methods to perform to the specific residinstructions for performations for performing to the specific residinstructions for performations for performing the specific resident in the resident in	ed personnel were to perform ment services for the resident. In nursing services to embers only after determining person was trained and been instructed in the proper in the procedures with respect ent. Including written forming the procedure for the dent record. Treatment or the delegated or assigned by a fessional to unlicensed g to the licensed health cable licensing practice treatment or therapy was used personnel, the RN "must" sed personnel in the proper the treatment or perform the each treatment and unlicensed personnel had ability to competently follow the	01380				
01420 SS=F	(b) When the regist professional delegate personnel, that personnel the delegation the unit he proper method procedures for each demonstrate the above the delegation of the d	elegation of assisted living ered nurse or licensed health ates tasks to unlicensed son must ensure that prior to unlicensed personnel is trained ads to perform the tasks or h resident and is able to oillity to competently follow the form the tasks. If an	01420				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER	STREET ADI 204 14TH AUSTIN, N	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01420	unlicensed personn the delegated assis 24 consecutive mor must demonstrate or registered nurse or professional. The rehealth professional for the delegated ta This MN Requirements by: Based on observation review, the licensed registered nurse (Rocompetency evaluated personnel (ULP-E, delegated tasks.) This practice resultation violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents). The findings included ULP-E had a hire defended to administ applied to guards at the consequence of the conseq	tel has not regularly performed ted living task for a period of on the task to the unlicensed personnel competency in the task to the appropriate licensed health egistered nurse or licensed must document instructions sks in the resident's record.  The task to the appropriate licensed health egistered nurse or licensed must document instructions sks in the resident's record.  The task is not met as evidenced on, interview, and record efailed to ensure the N) conducted training and tions for two of two unlicensed ULP-F) who performed  The task is a level two violation (at harm a resident's health or obtential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all estate of May 11, 2022.  The task is 13 a.m. ULP-E was ster medications to R2 and to R2's right and left great and documented training and	01420			
	(mechanical lift use	tion for EZ stand lift d to transfer a person form and BRODA chair (medical				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01420	Continued From pa	ge 80	01420			
	equipment used whand maintain mobil	nen sitting to reduce pressure ity) use.				
	ULP-F had a hire d	ate of August 11, 2022.				
		ked documentation for training valuation for BRODA chair use.				
	stated, "Never hear At 9:47 a.m., RN-B nurse (LPN)-G had evaluated ULP-E for verified ULP-E had evaluation by a RN	2022, at 9:12 a.m. RN-B rd of BRODA chair training." stated licensed practical trained and competency or delegated tasks. RN-B no training or competency for EZ stand lift. RN-B re trained or competency chair use.				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01440 SS=D	144G.62 Subd. 4 S delegated nurs	upervision of staff providing	01440			
	therapy tasks must appropriate license registered nurse ac facility's policy when provided to verify the performed competer and solutions related to perform the task performing medical administration shall nurse or appropriate	rm delegated nursing or be supervised by an d health professional or a coording to the assisted living re the services are being nat the work is being ently and to identify problems ed to the staff person's ability s. Supervision of staff tion or treatment I be provided by a registered e licensed health professional bservation of the staff				

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
KSMS OUR HOUSE LLC  204 14TH ST NW AUSTIN, MN 55912  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DAT			30630	B. WING		09/	12/2022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE  DAT			204 14TH	ST NW	STATE, ZIP CODE		
	PRÉFI	X (EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE
administering the medication or treatment and the interaction with the resident.  (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.  This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for one of two unlicensed personnel (ULP-E).  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 staff are involved, or the situation has occurred only occasionally).  The findings include:  ULP-E's employee record lacked documented evidence of a registered nurse (RN) supervising ULP-E performing delegated tasks.  ULP-E had a hire date of May 11, 2022.	0144	administering the minteraction with the (b) The direct super delegated tasks mucalendar days after individual begins we performs the delegated requirement also apperformed delegated. This MN Requirement also apperformed delegated. This many performed delegated. This many performed delegated. This many performed delegated. This many performed delegated. This practice results was provided within date on which the interest that the facility for one of (ULP-E).  This practice results violation that did not safety but had the president's health or cause serious injury was issued at an is limited number of a limited number of a limited number of situation has occurred. The findings included ULP-E's employee evidence of a registration of the performing of the performance of the perfo	nedication or treatment and the resident. rvision of staff performing ast be provided within 30 the date on which the orking for the facility and first ated tasks for residents and ed based on performance. This oplies to staff who have not ed tasks for one year or longer.  ent is not met as evidenced ion, interview, and record a failed to ensure direct performing delegated tasks in 30 calendar days after the individual begins working for of two unlicensed personnel ed in a level two violation (a st harm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a residents are affected or one or staff are involved, or the red only occasionally).  e:  record lacked documented tered nurse (RN) supervising delegated tasks.	01440			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE COMP	SURVEY LETED		
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	204 14TH	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01440	observed to administ applied toe guards toes.  On September 12, stated, "No, not by a supervised by an R as required.  The licensee's Minr Medication Manage Policy dated June 2 evaluate the team retreatment at least the ensure the team metreatment appropria.	ster medications to R2 and to R2's right and left great  2022, at 9:47 a.m. RN-B an RN," regarding ULP-E was N performing delegated tasks  nesota Delegation of the ment and Treatment Services (2020, indicated the RN would nember's ability to perform the nirty (30) days after trained to ember was completing the ately and accurately.	01440			
01620 SS=G	be conducted no mafter initiation of ser reassessment and as needed based or resident and cannot from the last date of (d) For residents or services specified in 9, clauses (1) to (5) individualized initial and preferences. The completed within 30	essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted in changes in the needs of the texceed 90 calendar days	01620			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
KSMS O	UR HOUSE LLC	204 14TH				
	OLIMANA DV. OTA	AUSTIN, N		PROVIDERIO PLAN OF CORRECTIV		4.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 83	01620			
	the needs of the rescalendar days from (e) A facility must in of the availability of long-term care consection 256B.0911, prospective resident facility or the date or resident moves in, or This MN Requirements.  This MN Requirements assed on observation review, the licenses registered nurse (R comprehensive reacondition for two of to falls, ER visits are to ensure the RN comprehensive	eeded based on changes in sident and cannot exceed 90 the date of the last review. If orm the prospective resident and contact information for sultation services under prior to the date on which a service a contract with a service of the earlier.  If each is not met as evidenced and contact with a service of the end of the earlier.  If each is not met as evidenced and contact with a service of the end of				
	violation that harmen not including serious or a violation that has serious injury, impaissued at an isolate limited number of realimited number of situation has occurr. The findings include R2 R2's diagnoses included R2 R2's Service Plan in R2's Service Plan in	ed in a level three violation (a ed a resident's health or safety, is injury, impairment, or death, as the potential to lead to irment, or death) and was d scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).  e:  luded dementia and repeated integrated into R2's 90-day ated August 9, 2022. R2's				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	including p.m. snaccheck, bathing, bow C-collar (neck braccompassionate touenvironmental assistance, hearing housekeeping, recowalking assistance, mobility equipment toileting assistance safety/wandering/elmonitoring/treatment indicated for skin caresident noted to hat top of right big toe. and bandaid will be guard to right toe whealed." The service for the service of easpiration precaution Resident is to remale eating. R2's services services of toe guarensure and mechal on September 7, 2 personnel (ULP)-E medications to R2 aright and left great the recliner in her room placed near R2's replace on R2's recliner COMPREHENSIVE R2's record lacked	ed R2 received services k, activity participation, alarm vel assistance/monitoring, e), communication, ch, dressing, eating, stance, evacuation II risk monitoring, grooming aid/glasses assistance, ord intake snacks, mobility and medication management, check, skin care treatment, supervision for opement, wellness of the shavior monitoring and are treatment May 27, 2022, ave an old healing blister on "Area will be observed daily applied for protection. Toe ill be held due to area until e plan/assessment indicated ating assistance resident is in on and mechanical soft diet. In upright 30 minutes after e plan lacked the treatment rds to right and left great toes, nical soft diet.  1022, at 8:13 a.m. unlicensed was observed to administer and applied toe guards to R2's coes. R2 was seated in a fully dressed. A walker was becliner and an alarm was in the comprehensive assessment ge in condition related to falls	01620			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KeWe O	UR HOUSE LLC	204 14TH	ST NW			
KSWS U	OK HOUSE LLC	AUSTIN, N	/N 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 85	01620			
	dates of February 8	ed R2 had 17 falls between the 2, 2022, and August 18, 2022.				
	identified injuries working room (ER) visits or related to falls for the	ere sustained, emergency hospitalization occurred				
	of pain. No injuries tract infection, antib	noted. Diagnosed with urinary				
	for pain. No injuries and no change in ordersMarch 8, 2022, small cut on right elbow. Assessment of R2 by licensed practical nurse (LPN)-G identified skin tear right elbow					
	measuring 2 centim	neters (cm) x 1 cm and bruise asuring 3 cm x 1.5 cm.				
	bump. R2 was com pain. Taken to ER.	ry to back of head large size plaining of neck and back Hospitalized due to bilateral				
	Returned back to fa	sferred to ER for evaluation. acility with no new orders. No				
		20 a.m. taken to ER due to Returned same day no new				
	orders and CT scar tomography imagin	n (CAT scan/computerized g) was performed with no new				
		, 2022, received call form ER read CT scan stating R2 had fracture				
	-June 4, 2022, at 6: (antibiotic) for three	13 p.m. continue Bactrim more days, upcoming				
	-June 6, 2022, bruis	neurology and family practice. sing to right elbow. oloration on right side of				
	forehead and right I	knee. Resident said head hurt. ed from ER, no bruising noted				

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REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O1620  Continued From page 86  R2's observation notes identified physical change in status for the following dates: -April 29, 2022, sent to ER bleeding from vaginal or anal region. Determined in ER to be from hemorrhoidsdated May 24, 2022, R2 kept stating she had to go and had pressure on her lower abdomen. R2 began to heave and vomited once while sitting on the toilet. R2 had a medium bowel movement. R2 had no fever and appeared to look better after going to the bathroom and laying downdated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to	Minnesc	ota Department of He	ealth				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  R2's observation notes identified physical change in status for the following dates: -April 29, 2022, sent to ER bleeding from vaginal or anal region. Determined in ER to be from hemorrhoidsdated May 24, 2022, R2 kept stating she had to go and had pressure on her lower abdomen. R2 began to heave and vomited once while sitting on the toilet. R2 had a medium bowel movement. R2 had no fever and appeared to look better after going to the bathroom and laying downdated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to				, ,			
CX4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PREFIX TAG   PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)   O1620      R2's observation notes identified physical change in status for the following dates: -April 29, 2022, sent to ER bleeding from vaginal or anal region. Determined in ER to be from hemorrhoidsdated May 24, 2022, R2 kept stating she had to go and had pressure on her lower abdomen. R2 began to heave and vomited once while sitting on the toilet. R2 had a medium bowel movement. R2 had no fever and appeared to look better after going to the bathroom and laying downdated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to			30630	B. WING		09/1	2/2022
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  R2's observation notes identified physical change in status for the following dates: -April 29, 2022, sent to ER bleeding from vaginal or anal region. Determined in ER to be from hemorrhoidsdated May 24, 2022, R2 kept stating she had to go and had pressure on her lower abdomen. R2 began to heave and vomited once while sitting on the toilet. R2 had a medium bowel movement. R2 had no fever and appeared to look better after going to the bathroom and laying downdated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to	NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTION SHOULD	KSMS O	UR HOUSE LLC		_			
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in status for the following dates: -April 29, 2022, sent to ER bleeding from vaginal or anal region. Determined in ER to be from hemorrhoidsdated May 24, 2022, R2 kept stating she had to go and had pressure on her lower abdomen. R2 began to heave and vomited once while sitting on the toilet. R2 had a medium bowel movement. R2 had no fever and appeared to look better after going to the bathroom and laying downdated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to	01620	Continued From pa	ge 86	01620			
push fluidsAugust 25, 2022, when I was next to R2 I noticed she was dry heaving. I grabbed a garbage can and she threw up a little bit of Ensure drink (supplement), then threw up a little more. No fever, vitals were normal. R2 was asked if she had pain anywhere and she tapped her hand on her stomachdated August 26, 2022, when I was next to R2 I noticed she was dry heaving. I grabbed a garbage can and she threw up a little bit of Ensure drink (supplement), then threw up a little more. No fever, vitals were normal. R2 was asked if she had pain anywhere and she tapped her hand on her stomach.  The following 90-day Assessments for R2 documented completed by RN-B were provided: -dated January 26, 2022 -dated April 22, 2022 -dated May 13, 2022 -dated August 9, 2022  Although interventions were implemented following falls, R2's record lacked documented		in status for the follo-April 29, 2022, sen or anal region. Determined the morrhoids.  -dated May 24, 202 go and had pressur began to heave and the toilet. R2 had a had no fever and argoing to the bathrod-dated June 2, 2022 is odorous and dark push fluids.  -August 25, 2022, vishe was dry heavin and she threw up a (supplement), then fever, vitals were not had pain anywhere her stomach.  -dated August 26, 2 noticed she was dry garbage can and she Ensure drink (supplemore. No fever, vital sked if she had pain her hand on her stomath on her st	owing dates: Int to ER bleeding from vaginal ermined in ER to be from  22, R2 kept stating she had to re on her lower abdomen. R2 d vomited once while sitting on medium bowel movement. R2 ppeared to look better after om and laying down.  2, staff reported resident urine k. Staff were encouraged to when I was next to R2 I noticed ig. I grabbed a garbage can a little bit of Ensure drink threw up a little more. No ormal. R2 was asked if she and she tapped her hand on 2022, when I was next to R2 I y heaving. I grabbed a he threw up a little bit of lement), then threw up a little als were normal. R2 was ain anywhere and she tapped omach.  By Assessments for R2 leted by RN-B were provided: 2022 22 22 22 22 22 22 22 22 22 22 22 2				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC		204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	evidence of compre RN for change in co physical change in On September 6, 2 entrance conference process if a fall occ of motion and vital a transport out or ass doctor are notified. out and the nurse re implements interve present. If the nurse [resident care atten next time the nurse would assess the re notified after every process of ER visits when coming back building the on call access to ECP [cor see the resident or information in the c return from hospita assessment" (comp completed. RN-B si not completed with ER visit was comple	chensive assessment by the condition related to falls and status.  022, at 10:27 a.m. during the se registered nurse stated the surred was "first assess range signs to determine if need to sisted. Family and medical A Resident Event form is filled eviews the form and ntions. Nurse assesses if e is not present, then the RCA dant] follows a list and the is in the building the nurse esident. The nurse on call is fall." RN-B stated for the se "the nurse receives a call and if the nurse is not in the nurse gets called. We all have mputer system] to determine to not and can update are plan." RN-B stated upon lization, "if gone 24 hours a full brehensive) would be tated a full assessment was an ER visit, but a review of the eted.	01620			
	after falls" completi assessments of R2 condition related to was doing them", re stated she had com assessment on R2 hospital on May 13	2. RN-B stated, "No, I am not				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01620	for change in status of May 24, 2022, Ju 26, 2022. RN-B sta [R2] was August 9".  ACCURATE ASSES The license failed to by the RN.  On September 7, 2 was observed to hadevice) in place on bed.  On September 8, 2 stated the staff were R2 was given "Ensure."  R2's 90-day assess indicated "n/a" (not fluid (water, juice, consumed each dadevice" was not additem of "repositionir.  On September 12, verified the areas of intake and assistive appropriately on the R1  R1 has diagnoses to mild intellectual discobstructive pulmonary.	s as noted above for the dates ine 2, 2022, August 25 and ited, "My last assessment for SSMENT of ensure accurate assessment of the open of the open of the ensure accurate assessment of the open of the ensure accurate assessment of the open of the open of the ensure accurate assessment of the open of the ensure accurate assessment of the date of the open of the ensure accurate assessment of the open of the open of the ensure accurate assessment of the open o	01620			
	R1 received service	es including medication				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01620	management, blood dressing/grooming showers, skin care alcohol/ tobacco su SMOKING OBSER R1's Our House As 16, 2022, in section indicated check ma "Smokes/chews tol recreational drug us assist outside." The "Alcohol/Tobacco-sincluded the following outside and smoon the patio. Staff whas exhibited safes to let himself back problems arise from director. Cigarettes closet at all times. On September 7, 2 a.m. ULP-E stated receive a cigarette would get a cigarette was lit.  On September 7, 2 a.m. R1 was observed plastic trash liner in can contained multiple contained contained multiple contained contained multiple contained contained multiple contained	d sugar checks, reminders, stand by assist for behavior management, and apervision.  EVATION  Seessment MN dated August 17. Habits/Routines 18. Park next to sentence, bacco, alcohol consumption, se supervision needed 18. Park next in the facility after smoking practices and is able in the facility after smoking. If n smoking, ULP to notify will be locked in the med Guardian will supply cigarettes	01620			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
30630	B. WING		09/	12/2022	
204 147	ADDRESS, CITY, ST	TATE, ZIP CODE			
KSMS OUR HOUSE LLC AUSTIN	I, MN 55912				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
surveyor observed two cigarette receptacles approximately 20 steps from the bench further down the sidewalk. At the same time, ULP-F was observed smoking just beyond this area.  On September 7, 2022, at approximately 11:30 a.m. ULP-F indicated R1 usually "snubbed out" his cigarette on the ground and placed the butt in the trash can next to the bench. ULP-F agreed that the plastic trash can and plastic liner was not safe and presented a fire hazard. ULP-F stated, "The director talked last week about getting an appropriate container there for the residents to use, but this has not happened yet." ULP-F confirmed that she watched R1 use the plastic trash can to place his extinguished cigarette butts in "one of those smoking thingys". When asked if he uses anything else, he stated that "most of the time" he "used the smoking thingy out there." R1 denied using the plastic trash can by the patio bench to discard his cigarette butt.  On September 7, 2022, at approximately 11:40 a.m. RN-B and RN-C both agreed that the plastic trash can with the plastic liner was a fire hazard and dangerous. RN-C stated that they had a discussion last Friday at a staff meeting about finding a proper receptacle for the residents' cigarette butts, and the plastic trash can was not out there at that time. RN-C stated that the staff from the weekend likely placed the trash can out there because they were "sick of picking up the cigarette butts the staff were using, and would immediately move one of them next to the bench	n ot c				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	Continued From pa	ige 91	01620			
	an "event and condindicated R1 was e Room for concerns "copious amount of front of the toilet and sent by ambulance and returned to the with a new antibiotisuspected urinary to March 30, 2022 Other: update to EFLPN-G indicated "nassessment section concern for "Bladde" "Urinary tract infect genitourinary conceindication of new bithis assessment.	ern entry" in R1's record, and valuated in the Emergency with blood from penis with blood found on the floor in ad inside the toilet." R1 was to the Emergency Room (ER), facility that same day with c order for Cefdinir for a ract infection.  Property of the completed by the identified items in a identified for areas of er." Areas that included items (UTI's) and other erns were left blank. No other cood or ER trip was included in 2022, at approximately 12:00				
	p.m. RN-B confirme completed by a RN	ed the assessment was not as required.				
	a.m. by LPN-G, ind ER for a nose bleed rated at "6 and gett paperwork was initi the ER. LPN-G do to request a discha prescriber orders. If document dated Jusummary" from tha	ntry on June 9, 2022, at 8:30 icated R1 was evaluated in the d and headache reported to be ing worse". No follow up ally returned to the facility from cumented contact was made rge summary and any new R1's record included a ine 7, 2022, named "After visit t ER visit and included edication management related				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	to R1's nosebleed. R1's record indicate appointment on Junbeing evaluated by changes in medicate discontinue aspirin, Neil med sinus rinse orders were noted to R1's record lacked following a change on June 7, 2022, or June 14, 2022. On September 12, 2p.m. RN-B confirmer required RN assess condition.  ACCURATE ASSES On September 7, 20 a.m. ULP-E was ob R1 as subcutaneou R1's Our House Assassessment dated Athat R1 assisted within sulin. The assess section labeled "Adwith check mark by "Monitoring of self a orders) or medication resident's ability to self-administration vinsulin.	ed that R1 had a follow up the 14, 2022, where he was a new provider who provided ion orders that included: rose geranium nasal spray, and Vaseline to nares. The by LPN-G on June 14, 2022. required RN assessment in condition after R1's ER visit follow up appointment on  2022, at approximately 12:00 and R1's record lacked the ament following a change in  SSMENT  222, at approximately 8:45 served to administer insulin to a injection into his abdomen. Sessment MN-90 day August 16, 2022, indicated h self-administration of ament included a statement in ditional Medication Needs" selection indicating administered insulin (doctor ons (RN must evaluate self administer meds)." cked clear indication of versus staff administration for	01620			
	The August Medica	tion Administration Record				

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Minnesota Department of Health

30630 B. WING 09/12/202	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
			B. WING	30630		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		STATE, ZIP CODE	RESS, CITY,	STREET AD	PROVIDER OR SUPPLIER	NAME OF F
KSMS OUR HOUSE LLC 204 14TH ST NW AUSTIN, MN 55912					OUR HOUSE LLC	KSMS O
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPANY OF LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X4) ID PROVIDER'S PLAN OF CORRECTION (X COMPANY OF LSC IDENTIFYING INFORMATION)	RECTIVE ACTION SHOULD I RENCED TO THE APPROPR	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PREFIX	MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PRÉFIX
(MAR), indicated R1 had an increase in his dose of quetiapine (medication for agitation/insomnia). Dosing was increased from 12.5 milligrams [mg] to 50 mg daily. On August 2, 2022, R1's record indicated an "observation" note written by LPN-G indicating R1 was seen by a provider on doctor rounds for a routine visit. Recent behaviors were discussed. New order was noted for increase quetiapine from 12.5 mg to 50 mg every day at 6.00 p.m. new order was added to MAR, pharmacy notified, and guardian notified.  R1's assessment dated August 16, 2022, lacked information related to needed increase in quetiapine dosing or increased behavior reflecting needed dose increase. Same assessment included a medication (risperidone) given for mood/agitation, that R1 no longer received.  August 16, 2022, assessment indicated "not applicable [NA]" to assessment areas of "diversion of medications" and "fluid intake".  R1's assessment dated August 16, 2022, lacked the required content of comprehensive assessment to include: spiritual/cultural preferences, transportation, medications (resident preferences, transportation, medications) of not medication and the assessment dated August 16, 2022, lacked complete and accurate information in the assessment regarding the self-administration of insulin was "a corporate requirement" and needed to have the wording adjusted to reflect an accurate information of how R1's insulin is given. LALD-A and RN-B			01620	I had an increase in his dose cation for agitation/insomnia). ed from 12.5 milligrams [mg]  R1's record indicated an written by LPN-G indicating R1 ider on doctor rounds for a tabehaviors were discussed. ed for increase quetiapine mg every day at 6:00 p.m. ed to MAR, pharmacy notified, ed.  ated August 16, 2022, lacked to needed increase in r increased behavior reflecting ise. Same assessment on (risperidone) given for tall no longer received.  assessment indicated "not assessment areas of ations" and "fluid intake".  ated August 16, 2022, lacked to f comprehensive ide: spiritual/cultural ortation, medications (resident psychological stress and ous placements.  2022, at approximately 12:00 LALD-A. RN-B confirmed the August 16, 2022, lacked rate information. LALD-A mation in the assessment administration of insulin was "a ent" and needed to have the reflect an accurate indication	(MAR), indicated R of quetiapine (medi Dosing was increas to 50 mg daily. On August 2, 2022, "observation" note was seen by a provroutine visit. Recen New order was note from 12.5 mg to 50 new order was add and guardian notified R1's assessment d information related quetiapine dosing coneeded dose increas included a medicati mood/agitation, that August 16, 2022, as applicable [NA]" to "diversion of medic R1's assessment dather required content assessment to inclupreferences, transpreference), risk for unsuccessful previous On September 12, p.m. with RN-B and assessment dated accomplete and accurated that the infor regarding the self-accorporate requirem wording adjusted to	01620

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Minneso	<u>ta Department of He</u>	<u>alth</u>				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	The licensee's Care 2022, indicated dire appropriate strategi potential harmful be risk. Any time a result nursing home or other sident prior to the resident prior to the resident sident prior to pland ensure adequated significant changes falls, injuries, bruisi behavioral incidents physical, or sexual attempts, wanderin ISP was required to knowledge of the incondition. If the direct update the ISP, the team member to we information on the standard sign off on the the update. The direct prior to the prior t	ing required assessment				

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No further information was provided.

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	Continued From page 95		01620			
01640	TIME PERIOD FOR CORRECTION: Twenty-One (21) days		01640			
SS=E	40 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to		01640			
	that services are fir facility shall finalize (b) The service plan include a signature facility and by the reagreement on the service plan must be resident reassessmallity must provide about changes to the and how to contact Long-Term Care. (c) The facility must services required be (d) The service plan must be entered intincluding notice of a when applicable.	calendar days after the date st provided, an assisted living a current written service plan. In and any revisions must or other authentication by the esident documenting services to be provided. The services to be provided. The services desired, if needed, based on sent under subdivision 2. The serior in the facility's fee for services the Office of Ombudsman for the implement and provide all by the current service plan. In and the revised service plan to the resident record, a change in a resident's fees services must be informed of service plan.				
	by: Based on observati review, the licensee	ent is not met as evidenced on, interview and record e failed to ensure the service ith changes in services for two 2, R1).				
	This practice result	ed in a level two violation (a				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01640	violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited numb situation has occurrifound to be pervasi.  The findings include R2 R2's service plan latreatment services guards to right and (supplement) and not required total assist undressing. C-collated Attempts to take off instructions indicated breakdown due to to C-collar use. May have an old healing "Area will be observapplied for protection be held due to area plan/assessment in eating assistance reprecaution and meet to remain upright 30 service plan lacked	ot harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a residents are affected, more per of staff are involved, or the red repeatedly; but is not ve).  The collar (neck brace), toe left great toes, Ensure nechanical soft diet.  The defendent and repeated the grated into R2's 90-day August 9, 2022, indicated R2 tance with dressing and rused due to fracture.  The C-collar Called R2 was at risk for skin C-collar. Daily skin check due y 27, 2022, resident noted to be been been control by and Band-aid will be contro	01640	DETICIENCI)		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC 204 14TH AUSTIN,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01640	Continued From pa	ge 97	01640			
	September 2022, ir  On September 7, 2 personnel (ULP)-E medications to R2 a right and left great to recliner in her room have a C-Collar in p great toe was intact  On September 8, 2 stated the staff wer R2 was given "Ensure we push Ensure." A was not sure if R2 v not. ULP-D stated F	ration Record dated indicated the same.  022, at 8:13 a.m. unlicensed was observed to administer and applied toe guards to R2's toes. R2 was seated in a fully dressed and did not place. The skin on R2's right to (no blister was observed).  022, at 9:28 a.m. ULP-D e monitoring R2's intake and ure supplement. If not eating, at 9:32 a.m., ULP-D stated she was to be wearing C-collar or R2 was on a "mechanical soft neat was shredded, swallows				
	-dated April 25, 202 mechanical soft die mechanical soft die kitchen for staff edu-dated May 26, 202 noticed a cut on big-dated June 28, 202 bottles for resident. given one time daily R2's record include -After Visit Summar which indicated "die mechanical soft (wl summary was not seprescriber order daplan to wear collars	2, when putting on toe guard, I toe. 22, family did bring Ensure Will request for this to be y. Awaiting doctor orders.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER  UR HOUSE LLC	204 14TH	ST NW	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01640	However, no furthe prescriber's order rediscontinued or not R2's record lacked prescriber's order for mechanical soft die R2's service plan la treatment services great toes, Ensure On September 12, nurse (RN)-B states the C-collar. RN-B [R2] would not leave only." RN-B verified above.  R1 The licensee lacked for the treatment see blood sugar checks R1's diagnoses incomild intellectual discobstructive pulmon hypertension (high R1's Service Plan in assessment dated received treatment management and be Assessment/Service in section "Wellnes indicated "Is on sch sugar checks four (On September 7, 2)	r information was provided for egarding if the collar was  documented evidence of a or the toe guards, ensure and et.  acked revision for the of toe guards to right and left and mechanical soft diet.  2022, at 10:13 a.m. registered d R2 no longer needed to wear stated, "It was discontinued. e it on. It was for six weeks I R2's service plan lacked the drevision of R1's service plan ervice of as needed (PRN) s.  luded type two (2) diabetes, ability, heart failure, chronic ary disease (lung disease), blood pressure) and insomnia.  Integrated into R1's 90-day August 16, 2022, indicated R1 services including medication blood sugar checks. R1's e plan dated August 16, 2022, s Monitoring/Treatments" needuled insulin and blood	01640			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
		AUSTIN, N	/N 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
01640	, , , , , , , , , , , , , , , , , , ,	ge 99	01640			
	dated August and S "blood glucose cher to 8 [eight] times per provide blood sugar 11:00 a.m., 5:00 p.r designated for PRN sugar check-use to [eight] times per da  R1's records lacked sugar checks, but in supplies of lancets check blood sugar)  R1's Service Plan la PRN blood sugar cl	d a prescriber order for blood not not a prescriber order for blood not and alcohol pads (used to for up to eight (8) times daily.				
	service plan lacked additional as neede	revision for providing the ed blood sugar testing.				
	Content Policy" date indicated "All reside up-to-date service provided based on registered nurse (R place are established individualized initial subsequent reassed Description of home	ed with revision of June 2020, ents/tenants have an olan identifying services to be the assessment by the N). Contents of the service ed after completion of a full assessment and each ssment. This included " a e care services including				
	treatments, and/or to our agency and the	ation management services, therapy services provided by frequency of each service sident/tenants current eferences."				

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Minnesota Department of Health

Minneso	ta Department of He	eaim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LLIED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KOMO O	UD HOUGE LLO	204 14TH	ST NW			
KSWS O	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG	REGOLATORT OR E	oo ibertii Tiivo iivi orviiivi Tiovy	TAG	DEFICIENCY)	TUVIL	
01640	Continued From no	ago 100	01640			
01640	Continued From pa	ige 100	01040			
	No further informati	ion was provided.				
	TIME DEDIOD TO	CORRECT: Twenty-one (21)				
	days	CORRECT: Twenty-one (21)				
	days					
01650	1//G 70 Subd // (f	) Service plan, implementation	01650			
SS=F	and revisions to	) dervice plan, implementation	0.000			
	(f) The service plan					
	• •	the services to be provided,				
		s, and the frequency of each				
		to the resident's current				
	assessment and re					
	who will provide the	n of staff or categories of staff				
		d methods of monitoring				
	assessments of the					
		d methods of monitoring staff				
	providing services;					
	(5) a contingency p					
		aken if the scheduled service				
	cannot be provided	; a method to contact the				
	facility;	a method to contact the				
		contact information of persons				
		to have notified in an				
	emergency or if the	re is a significant adverse				
		ent's condition, including				
		l information as to who has				
	, ,	the resident in an emergency;				
	and (iv) the circumstance	ces in which emergency				
		re not to be summoned				
		pters 145B and 145C, and				
		by the resident under those				
	chapters.	-				
	This MN Requireme	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	30630	B. WING		09/1	2/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
Kewe OUR HOUSE LLC	204 14TH	ST NW			
KSMS OUR HOUSE LLC	AUSTIN, I	MN 55912			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
review, the licensee of plan included all requiresidents (R2, R1).  This practice resulted violation that did not safety but had the poresident's health or swidespread scope (wor represent a system or has the potential to of the residents).  The findings include:  R2 R2's diagnoses inclufalls.  R2's Service Plan intrassessment was dat service plan indicated included p.m. snack, check, bathing, bower C-collar (neck brace) compassionate touch environmental assist assist/supervise, fall assistance, hearing a housekeeping, recommobility equipment couleting assistance, safety/wandering/elomonitoring/treatment indicated for skin car	on, interview and record failed to ensure the service uired content for two of two d in a level two violation (a harm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive mic failure that has affected to affect a large portion or all degrated into R2's 90-day ted August 9, 2022. R2's d R2 received services which, activity participation, alarmel assistance/monitoring, ), communication, h, dressing, eating, tance, evacuation risk monitoring, grooming aid/glasses assistance, d intake snacks, mobility and medication management, sheck, skin care treatment, supervision for	01650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC 204 14TH AUSTIN,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01650	and Band-aid will be guard to right toe whealed." The service for the service of earn aspiration precauses and and metaling. R2's services of toe guarensure and and metaling. R2's Task Administr September 2022, id providing the service plan.  On September 7, 20 personnel (ULP)-Exmedications to R2 aright and left great the recliner in her room have a C-Collar in personnel to was intact.  On September 8, 20 stated the staff were R2 was given "Ensure R2 was given "Ensure R2 was not sure if R2 wnot. ULP-D stated Fexture" diet and "metaling better."  R2's Service Plan late and according ensure, metaling services (each servation of the guards, ensure, metaling services (each servation accontingency plants accontingency plants accontingency plants accontingency plants accontingency plants according to the services (each servation according to the services (each servation accontingency plants according to the services (each servation according to the services (each servation according to the services (each servation according to the servat	e applied for protection. Toe ill be held due to area until e plan/assessment indicated ating assistance resident was ation and mechanical soft diet. In upright 30 minutes after e plan lacked the treatment rest to right and left great toes, echanical soft diet.  Tation Record dated dentified staff documented for es as indicated on R2's  D22, at 8:13 a.m. unlicensed was observed to administer and applied toe guards to R2's oes. R2 was seated in a fully dressed and did not place. The skin on R2's right (no blister was observed).  D22, at 9:28 a.m. ULP-D emonitoring R2's intake and are supplement. If not eating, at 9:32 a.m., ULP-D stated she was to be wearing C-collar or R2 was on a "mechanical soft leat was shredded, swallows acked the following: e services to be provided (toe chanical soft diet), the fees for	01650			

Minneso	<u>ta Department of He</u>	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
140140 01	UD 110110E 1 1 0	204 14TH				
KSWS U	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01650	intellectual disability obstructive pulmona (high blood pressur dependence.  R1's Service Plan dindicated R1 receiv blood sugar checks reminders, stand by behavior managem supervision.  On September 7, 2 a.m. ULP-E was obsugar check in his result.  R1's Service Plan (assessment) indicated four times.  R1's August and Sea Administration Received four times.  R1's August and Sea Administration Received four times. Administration Received four times. Administration Received for providing checks up to eight to times of 7:00 a.m. and R1's August and R1's August and R1's Service plan late. (PRN) blood sugar.  R1's Service Plan late. General R1's Service Plan late. Gen	Juded type two diabetes, mild y, heart failure, chronic ary disease, hypertension e), insomnia and nicotine alated August 16, 2022, ed services which included s, dressing/grooming y assist for showers, skin care, ent, and alcohol/ tobacco assist R1 with blood room.  Jude a sproximately 11:00 asserved to assist R1 with blood room.  Jude a sproximately 11:00 assist R1 wit	01650			
		eduled service cannot be				

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Minnesota Department of Health

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
KSMS O	JR HOUSE LLC	204 14TH	_			
040.15			/N 55912	DDOVIDEDIC DI AN OF CODDECTIO		0.75
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
01650	Continued From pa	ge 104	01650			
	provided.					
	nurse (RN)-B verific lacked the above coliving director (LALE had a contract with who would be able and LALD-A confirm was not indicated o outside service provesidents' service p content required as  The licensee's Controller revised June would include the reto the assisted living	tents of Service Plans MN 2020, indicated service plans equired content as according g statute 144G.70 Subd.4.(f.).				
01710 SS=E	144G.71 Subd. 3 In monitoring and reas	dividualized medication	01710			
	reassess the reside services as needed resident presents w	facility must monitor and ent's medication management under subdivision 2 when the ith symptoms or other issues tion-related and, at a				
	by:	ent is not met as evidenced on, interview and record failed to ensure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01710	reassessment of m services at a minim residents (R2, R1).  This practice result violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited numb situation has occurrifound to be pervasi.  The findings include R2 had an admissid diagnoses including R2's Service Plan in assessment dated received services with management.  On September 7, 2 personnel (ULP)-E medications to R2.  R2's medication as 90-day assessment indicated "company medications." Curre [medication administrated "company medications are in extended Care Proprescriptions, over supplements. Including frequency, diagnos	edication management and annually for two of two ed in a level two violation (a tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).  e:  on date of July 27, 2021, with y dementia and repeated falls.  Integrated into R2's 90-day August 9, 2022, indicated R2 which included medication  022, at 8:13 a.m. unlicensed was observed to administer  sessment integrated into R2's to dated August 9, 2022, it to administer all ent medications are on "MAR estration record]. Side effects in medication portion of a List all medications including the counter medications and de name, dosage, route,	01710			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7. BOILDING.			
	30630	B. WING		09/1	2/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
allergies: NSAIDS [usinflammation]. Medica potential for medication interventions to prever applicable]".  R2's MAR dated Augumere administering or gout, four supplement hypothyroidism, one used for pain, one used for pain, one used for dry eyes, one one used for sore three effects, contraindication interventions, and advancessary intervention of the medications as medication assessment.  R2's record lacked a by the registered nursiface-to-face with the required content: -documentation the aface-to-face with the reductions, side effect allergic or adverse readdress these issues identify interventions medications to prevent the resident or others the medications and preventions are preventions and preventions and preventions and preventions are preventions and preventions and preventions and preventions and preventions and preventions and preventions are preventions.	s and necessary AR. List any medication sed to relieve pain/reduce ation assessment of the on diversion and ent diversion. n/a [not  ust 2022, indicated staff ne medication used to treat used for sleep, four used for ed for depression, one used strengthen bones, three e used for restlessness and oat. The MAR lacked side ions and necessary verse reactions and ons and indications for some is indicated on R2's ent.  medication reassessment se (RN) conducted resident, with the following assessment was conducted resident; and view of indications for ects, contraindications, actions, and actions to is needed in management of ant diversion of medication by who may have access to provide instructions to the designated representatives anage the resident's	01710			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01710	0 Continued From page 107		01710			
	verified R2's medic above and R2's red the RN for review o medications being were any side effect	2022, at 10:13 a.m. RN-B ation reassessment lacked the ord lacked documentation by f administration of given to R2 regarding if there its, contraindications, allergics, and actions to address				
	R1 R1 had an admission date of May 3, 2021, with diagnoses including mild intellectual disability, heart failure, type 2 diabetes, chronic obstructive pulmonary disease (constriction of breathing airways), and depression.					
		ntegrated into R1's 90-day August 16, 2022, included ement.				
		022, at 8:45 a.m. ULP-E was ster medications to R1.				
	90-day assessment indicated "company medications." Curre Side effects and dia portion of extended including prescription medications and sudosage, route, frequent contraindications and adverse reaction interventions. See I allergies: no known assessment of the	ent medications are on "MAR. agnosis are in medication Care Pro. List all medications ons, over the counter applements. Include name, uency, diagnosis, side effects, and necessary interventions, ons and necessary MAR. List any medication allergies. Medication potential for medication ventions to prevent diversion.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER UR HOUSE LLC	204 14TH	DDRESS, CITY, ST I ST NW MN 55912	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01710	R1's MAR dated Auwere administering hypertension (high cholesterol, three for acid reflux, five sleep, two for agitatic COPD, two for nascone for thick toenaid R1's record indicate additions/changes:  June 7, 2022, use for nose bleeds  -August 2, 2022, included for agitation at R1's record lacked by the RN conductor resident, with the form of the face-to-face with the dentification and resident and resident or adverse address these issued identify intervention medications to prevente resident and legal confined in the medications and predications.  On September 12, p.m. RN-B verified reassessment lacked acked documentation the face-to-face with the medications and predications and predications and predications.	igust 2022, indicated staff two medications for blood pressure), one for high or heart failure/chest pain, one for type 2 diabetes, two for tion/depression, three for all dryness/nose bleeds, and lls.  ed medication  of Afrin nasal spray as needed creased dose for quetiapine and insomnia).  a medication reassessment ed face-to-face with the bllowing required content: assessment was conducted e resident; and eview of indications for affects, contraindications, reactions, and actions to es; and and nash needed in management of a provide instructions to the or designated representatives manage the resident's event diversion of				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, Joi <u>l</u> J.			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH AUSTIN,						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01710	contraindications, a and actions to addr  The licensee's Minr Medication Manage Policy dated June 2 evaluate the effectividentify any drug to or reported side effective No further information	ere any side effects, llergic or adverse reactions, ess these issues.  nesota Delegation of ement and Treatment Services 2020, indicated the RN would veness of the medications and drug interaction and untoward ects.	01710			
01730 SS=E	management plan  (a) For each reside	dividualized medication  nt receiving medication	01730			
	management service must prepare and it written statement or services that will be facility must develo individualized medicach resident base assessment that m (1) a statement design management service (2) a description of on the resident's nediversion, and considirections; (3) documentation or relating to the admit (4) identification of	ces, the assisted living facility include in the service plan a f the medication management is provided to the resident. The p and maintain a current cation management record for				

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	
	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW	···· <u>-</u> , <u>-</u> ·· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01730	medication refills an (5) identification of tasks that may be opersonnel; (6) procedures for some a problem ari management service (7) any resident-specifications that all as prescribed, and to prevent possible reactions. (b) The medication current and updated changes. (c) Medication recowhen a licensed nuprofessional, or aut medication managements (R2, R1). This practice result violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number of re	re ordered on a timely basis; medication management lelegated to unlicensed staff notifying a registered e licensed health professional ses with medication ces; and ecific requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse management record must be d when there are any nciliation must be completed rese, licensed health horized prescriber is providing ement.  The sent is not met as evidenced on, interview and record efailed to ensure an cation management plan to content for two of two safety, but was not likely to by, impairment, or death) and tern scope (when more than a desidents are affected, more over of staff are involved, or the red repeatedly; but is not	01730			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
KSMS C	OUR HOUSE LLC	204 14TH AUSTIN,	IST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 111	01730			
	assessment dated a received medication.  On September 7, 2 personnel (ULP)-E medications to R2.  R2's individualized record integrated in dated August 9, 202 administer all medicare on "MAR" (medicate on "MAR" (medicate on "MAR" (medicate on traindications and sudosage, route, frequentral indications and adverse reaction interventions. See Mallergies: NSAIDS (inflammation). Medication to preapplicable).  R2's MAR dated August 9, 202 administer reaction interventions and sudosage, route, frequent reaction interventions. See Mallergies: NSAIDS (inflammation). Medication potential for medication interventions to preapplicable).  R2's MAR dated August 9, 202 administering gout, four supplement hypothyroidism, one us (duloxetine), one us strengthen bones (a	August 9, 2022, indicated R2 n management.  O22, at 8:13 a.m. unlicensed was observed to administer medication management to R2's 90-day assessment 22, indicated company to cations. Current medications ication administration record). Augusts are in medication Care Pro. List all medications ons, over the counter pplements. Include name, uency, diagnosis, side effects, and necessary interventions, ons and necessary MAR. List any medication used to relieve pain/reduce ication assessment of the ation diversion and vent diversion. n/a (not one medication used to treat ents, one used to treat ents, one used for sleep, four used for				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		30630	B. WING		09/1	2/2022
NAME OF PROVIDER	R OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOU	SE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
effects intervenecess of the medica. The M medica. The M medica. R2's M (used websit delaye chew, delaye with lice. R2's M alendreneces	entions, and a sary interven medications ation assess ation assess ations.  IAR indicated ations at a series at a serie	ations and necessary adverse reactions and tions and indications for some as indicated on R2's ment dated August 9, 2022. I "okay to crush" for duloxetine on); however, according to the is gov directed "swallow the psules whole; do not split, m. Do not open the psules and mix the contents ikle the contents on food."  Ilirection for administration of for bone strength); according lineplus.gov "You must take ter you get out of bed in the u eat or drink anything. Never to bedtime or before you wake ed for the day. After you take to eat, drink, or take any other ding vitamins or antacids) for at you not lie down for at least 30 minutes have be alendronate. Sit upright or at least 30 minutes have be alendronate tablets, with a full glass (6 to 8 ounces) are take alendronate tablets, with a full glass (6 to 8 ounces) are take alendronate tablets or take alendronate tablets. The many liquid other than plain tablets whole; do not split, and Do not suck on the tablets." The series for alendronate dated June the direction of take with eight an empty stomach, remain the MAR lacked the	01730			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				D WING		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
01730	direction for the ale prescriber orders.  In addition R2's MA hours apart for systeyes four times dail eyes), parameters of Metamucil powder of in beverage and take for which PRN eye artificial tears) to give R2's individualized record lacked the fora description of stothe resident's needs diversion, and considerations; documentation of serelating to the adminidentification of permonitoring medicates medication refills are identification of medication resident-specifications that all as prescribed, and	ndronate medication as per  R lacked parameters for ane eye drops (one drop both y as needed (PRN) for dry for the amount to give for (mix 1-2 rounded tablespoons are once daily) and parameters drop medication (Systane or we first.	01730			
	nurse (RN)-B verifie	2022, at 10:13 a.m. registered ed R2's individualized ement record lacked the above				
		ntegrated into R1's 90-day August 16, 2022, indicated R1				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
KSMS OUR HOUSE LLC		ST NW MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01730	received services in management.  On September 7, 2 observed to admini including: aspart insulin flex-p subcutaneously (un abdomen.  R1's medication as 90-day assessment indicated "company medications." Curred Side effects and diaportion of extended including prescription medications and sudosage, route, frequentraindications and adverse reaction interventions. See I allergies: no known assessment of the diversion and intervention (high cholesterol, three for acid reflux, five sleep, two for agitat COPD (congestive disorder), two for no one for thick toenai.  R1's August 16, 2021 labeled "additional in the standard reduction and interventions."	ncluding medication  022, at 8:45 a.m. ULP-E was ster medications to R1  ven, 10 units with breakfast, ader skin in fatty tissue) in  sessment integrated into R2's to administer all ent medications are on "MAR. agnosis are in medication Care Pro. List all medications ons, over the counter applements. Include name, uency, diagnosis, side effects, and necessary interventions, ons and necessary MAR. List any medication allergies. Medication potential for medication rentions to prevent diversion.  '.'  agust 2022, indicated staff two medications for blood pressure), one for high or heart failure/chest pain, one for type 2 diabetes, two for tion/depression, three for obstructive pulmonary asal dryness/nose bleeds, and	01730			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH AUSTIN. I		ST NW IN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
01730	of self-administered medications (RN m to self administer m R1 does not self-ad on staff to administer m R1's individualized record lacked the fora description of stothe resident's needs diversion, and considerations; -documentation of selections; -documentation of permonitoring medicat medication refills are identification of medication refills are identification of medication resident-specifications that all as prescribed, and to prevent possible reactions  On September 12, verified R1's assess information regarding as staff administered "this is what the conneeds to be remove R1's individualized record lacked the area.	d insulin (doctors's orders) or ust evaluate resident's ability neds." Iminister his insulin and relies er. Imedication management following: orage of medications based on and preferences, risk of istent with the manufacturer's especific resident instructions instration of medications; resons responsible for ion supplies and ensuring that recordered on a timely basis; redication management tasks ted to unlicensed personnel; fic requirements relating to reation administration, medications are administered monitoring of medication use complications or adverse  2022, at 12:15 p.m. RN-B sement included inaccurate ing insulin self-administration red the injection. RN-B stated mpany does, and this wording red." Additionally, RN-B verified medication management bove content.	01730			
	TIME PERIOD TO	CORRECT- Seven (7) days.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30630	B. WING		09/1	2/2022
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN, I	SINW MN 55912			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01750 Continued From p	age 116	01750			
01750 144G.71 Subd. 7 I SS=I administration	144G.71 Subd. 7 Delegation of medication				
to unlicensed personust ensure that to (1) instructed the component methods to and the unlicensed the ability to component (2) specified, in where the ability to component (3) communicated about the individual that in the resident's resident and in the resident's resident about the individual that ind	with the unlicensed personnel al needs of the resident.  nent is not met as evidenced tion, interview, and record to failed to ensure, prior to tasks, the one of one nel (ULP-E) was trained in the perform the task or procedure and were able to demonstrate etently follow the procedure to with employee record reviewed. Immediate correction order on 2, at approximately 10:40 a.m. ted in a level three violation (a ted a resident's health or safety, us injury, impairment, or death, has the potential to lead to airment, or death) and was read scope (when problems expresent a systemic failure that is potential to affect a large expression and the same and the same are sidents).				

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iviinneso	<u>ita Department of He</u>	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	E CONSTRUCTION	(X3) DATE COMPI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COIVIPI	LLIED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KeMe O	UR HOUSE LLC	204 14TH	ST NW			
KSIVIS O	UK HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01750	Continued From pa	ge 117	01750			
	On September 7, 2 observed to adminicely drop medication stated licensed pracher to do medication if a registered nurse observed her competo determine competo determine competon September 7, 2 observed to adminimedication and insupen to R1.	lay 11, 2022, and provided to residents.  022, at 8:13 a.m. ULP-E was ster oral medications and an n to R2. At the time, ULP-E ctical nurse (LPN)-G trained n administration. When asked e (RN) had trained and elete medication administration etency, ULP-E stated, "No."  022, at 8:45 a.m. ULP-E was ster oral medications, nasal ulin by injection via an insulin ation administration records ber 2022, indicated ULP-E				
	administered medic and 7, 2022. ULP-E's record incl -Orientation Checkl	3				
	Administration date LPN-G on July 27,	d July 27, 2022, signed by				
	signed by LPN-G.	lication Administration" dated				
	-Medication Observ signed by LPN-G fo	ration and Evaluation Forms or the dates of August 9, 11,				
	Routes dated July 2 July 27, 2022, for o eye drops, eye ointi	Medication Administration 27, 2022, signed by LPN-G on ral, sublingual, buccal, topical, ment, ear drops, transdermal ransdermal patch removal,				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH AUSTIN, N		_				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01750	Continued From pa	ge 118	01750			
	nasal spray, vagina proceduresSkill Competency I Nebulizer and Inhal signed by LPN-G or dose inhaler, dry porproceduresSkill competency I Administration Insu 27, 2022, and signe for insulin administration Insu and signed by LPN-pens procedureMedication Manag Training Completion and signed by LPN-8 Hour Medication and 5, 2022, and for observed by director passing medication process" on August -Educare (electronic Administration "ove 2022Educare Medication Insulin pen, nebuliz 2022.  ULP-E's employee of medications to R1 amedications to R1 amedicat	Medication and Treatment ers dated July 27, 2022, in July 27, 2022, for metered owder inhale rand nebulizer.  Medication and Treatment lin Administration dated July 26 by LPN-G on July 27, 2022, ation procedure.  Medication and Treatment lin Pens dated July 27, 2022, ation procedure.  Medication and Treatment lin Pens dated July 27, 2022, on July 27, 2022, for insulin lin Pens dated July 27, 2022, on July 27, 2022, for "Step 2: After Attending Training Class" on August 2, 3, recompleted buddy check 1, 11 and 12, 2022. The training program Medication review, routes dated July 19, and Treatment "Insulin, the line and Inhalers" dated July 20, record lacked documentation instration demonstrated N prior to administering				

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On September 9, 2022, at 10:07 a.m. RN-B

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01750	verified LPN-G had herself with ULP-E (without RN-B pres "the delegation to delegation of LPN-0"I've shown her how a.m., RN-B provide Delegation TN Nurs 27, 2021, for "assis competencies and procedures" and indeemed competent task/procedures ide by LPN-G and RN-	completed competency by for medication administration ent). RN-B stated LPN-G had to that" by her. RN-B stated for G to do competency with ULP, w to do the skill." At 10:54 d "LPN Competency for a sing Task" dated September at with Educare training, skill evaluation, nursing dicated LPN-G "has been at for delegated nursing entified above" and was signed B on September 27, 2021. The no specific details of what ucare training, skill	01750			
	Medication Manage policy dated revised RN will ensure that trained, competent, resident/tenant who are to perform med or treatments for the effectively "delegate responsibility for the task in a specific siteam member who task while the RN rethe outcome. Using RNs may delegate unlicensed personr such as RCA's, assecooks, consistent with MN home care required.	nesota Delegation of ement and Treatment Services d June 2020, indicated "The unlicensed personnel are and orientated to the enever unlicensed personnel lication management services e resident/tenant. The RN es" by transferring the e performance of a nursing tuation to another nursing is competent to perform the etains the accountability for a their professional judgement, nursing tasks to LPN's or nel (team member) categories sistance directors, LEC's, or vith the Nurse Practice Act, the uirements, accepted nursing ve (5) rights of delegation: 1.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022	
	PROVIDER OR SUPPLIER UR HOUSE LLC	204 14TH	DDRESS, CITY, ST I ST NW MN 55912	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
01750	Right task to be del circumstances 3. T The right directions right supervision to safely."  No further information of the safety	legated 2. Under the right he right person to the task 4. and communication 5. The ensure the task is carried out ion was provided.  R CORRECTION: IMMEDIATE 022, at 3:50 p.m. immediacy onfirmed by email the evaluation supervisor, but mains.  Ion, interview and record explication of explications of explications for edications, which was need personnel.  Integrated into R2's 90-day August 9, 2022, indicated R2 including medications to R2.	01750	DEFICIENC			
	record integrated in dated August 9, 202 administer all medic	medication management ato R2's 90-day assessment 22, indicated company to cations. Current medications lication administration record).					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
01750	Side effects and dia portion of extended including prescriptic medications and su dosage, route, frequent contraindications are and adverse reaction interventions. See I allergies: NSAIDS (inflammation). Med potential for medical interventions to preapplicable).  R2's MAR's dated A 2022, indicated state medication used to one used to treat hysleep, four used for depression, one us strengthen bones, the used for restlessneth throat. The MAR lack contraindications and and adverse reaction interventions and in medications as indiassessment dated A 2022, indicated "ok (used for depression website medlinepludelayed-release calchew, or crush ther delayed-release calwith liquids or sprint R2's prescriber ord	agnosis are in medication Care Pro. List all medications ons, over the counter applements. Include name, uency, diagnosis, side effects, and necessary interventions, ons and necessary was and necessary manual to relieve pain/reduce ication assessment of the ation diversion and went diversion. n/a (not august 2022 and September of were administering one treat gout, four supplements, prothyroidism, one used for each for pain, one used for each one used for each one used for dry eyes, one se and one used for sore cated addressing side effects, and necessary interventions, ons and necessary interventions, ons and necessary interventions, ons and necessary adications for some of the cated on R2's medication August 9, 2022.  August 2022 and September and to crush of the diversion of the second o	01750			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS OUR HOUSE LLC 204 14TH AUSTIN, I		_				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01750	water, on an empty minutes for alendro lacked the direction medication as per placked direction for R2's MAR also lack for Systane eye drottimes daily as need parameters for the powder (mix 1-2 robeverage and take for which PRN eye artificial tears) to girl. On September 12, verified R2's record	stomach, remain upright 30 onate medication. The MAR of for the alendronate prescriber orders. R2's MAR administration of alendronate. Red parameters for hours apart ups (one drop both eyes four led (PRN) for dry eyes), amount to give for Meta unded tablespoons in once daily) and parameters drop medication (Systane or	01750			
01760 SS=E	living facility staff m resident's record. T include the signature administered the m must include the m and time administe administration. The reason why medical completed as presently follow-up procedure the resident's need administered as presently included the second staff of the s		01760			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		00/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	09/1	2/2022
	UR HOUSE LLC	204 14TH		37,712, 211 3332		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01760	This MN Requirements: by: Based on observation review, the licensed was administered and administration of more prescribed for two condition, the licensed needed (PRN) medication that did not safety but had the president's health or cause serious injury was issued at a parallimited number of rethan a limited number o	ent is not met as evidenced ion, interview and record is failed to ensure medication as prescribed and direction for edication was transcribed as of two residents (R2, R1). In the failed to follow up on as dication effectiveness for one interview in a level two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to by, impairment, or death) and there is some involved, or the red repeatedly; but is not ve).	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	30630	B. WING		09/1	2/2022
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS OUR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
Metamucil powded 1-2 rounded tabled ULP-E obtained as and placed Metar the plastic spoon. Was to receive 1/2 halfway was 1/2 to mix the powder mixture to drink would ULP-E walked our mixture remaining administer the riginal failed to measure powder to ensure failed for on September 7, 9:00 a.m. The Mapowder 1-2 tables once daily for the On September 8. nurse (RN)-B state measured and all given.  The licensee's Appass Policy and Faozo, indicated reobserve the residensuring each pill TRANSCRIPTION The licensee failed.	E was observed obtain r with label directions of take spoon in beverage every day. plastic spoon (teaspoon size) nucil powder onto one half of At the time ULP-E stated R2 teaspoon and filled the spoon easpoon. ULP-E was observed in water and gave R2 the shille taking oral medications. To fR2's room with some of the pin the cup. ULP-E failed to the medication (Fiber orange), the amount of Metamucil 1/2 teaspoon was given and 2 drank all of the medication.  September 2022, identified administration of Fiber orange 2022, for the scheduled time of a indicated the Metamucil spoons was to be administered scheduled time of 8:00 p.m.  2022, at 2:27 p.m. registered ed the Metamucil should be of the medication should be of the medication should be of the medication should be main with the resident and ent swallowing each medication, is swallowed.	01760			

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
01760	R2's prescriber ordaincluded the direction water, on an empty minutes for alendro dated September 2 the alendronate me orders.  On September 12, 3 stated the direction medication should be prescriber orders.  R1 R1's physician orderindicated, "For suddicated, "For suddisprays of oxymetaz both nostrils regard.  R1's MAR's dated A 2022, indicated the 12 hour nasal sprays several sprays into nose bleed. August MARS indicated an time for this medical indicating staff adm.  The licensee failed for oxymetazoline (a and was administer daily when it was or in response to a not transport to the state of the service of the service of the service of the direction of the service of th	ers dated June 10, 2022, on of take with eight ounces of stomach, remain upright 30 nate medication. R2's MAR 022, lacked the direction for dication as per prescriber  2022, at 10:13 a.m. RN-B for the alendronate on the MAR as per  er from June 7, 2022, den nose bleed, apply several oline (Afrin) nasal spray to less of side of nose bleed."  August 2022, and September following: (Afrin 0.05%), administer both nostrils AS NEEDED for 2022, and September 2022 8:00 a.m. daily scheduled ation with various ULP initials inistered the nasal spray daily.  to follow the physician's order Afrin) nasal spray as written ing the nasal spray scheduled dered to be given as needed	01760			
		_og" indicated that on August				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022	
	PROVIDER OR SUPPLIER UR HOUSE LLC	STREET ADI 204 14TH AUSTIN, N	ST NW	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
01760	19, 2022, at 2:38 a. administered acetar with a note that indi legs." There was not the effectiveness of the pain.  The MAR lacked th for effectiveness wineeded basis.  On September 8, 2re that the (nasal sprawas not sure why the scheduled when it reshe would reach out for clarification and stated, "this is really would schedule this are already giving a scheduled basis an morning."  On September 12, 2 stated that the expensive with the reside effectiveness of any stated that the eMA mechanism within the check with resident documentation. RN documented follow-  The licensee's "PRI 2011, indicated that medication being addocuments on the back with resident documents on the back with resident documented follow-	m. and 9:02 a.m. staff minophen 500 milligrams (mg) cated "for pain in left foot and of further documentation as to of the acetaminophen given for  e required 30 minute follow up th medications given on an as  022 at 10:22 a.m. RN-C stated y) order was confusing and ne Afrin nasal spray was ead as needed. RN-C stated t to the nurse practioner (NP) update the order. RN-C y confusing as to why we s (Afrin) nasal spray when we mother nasal spray on a d even at the same time in the  2022, at 12:00 p.m. RN-B ectation is for staff to check ent after about a half hour for y as needed medication. RN-B in the eMAR to remind staff to and then provide follow up -B was unable to find any sup with these occurrences.  N use" policy revised March 9, after a half hour of dministered, the Med Passer back side of the PRN MAR the ation and initials the effect.	01760				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760	Continued From pa	ge 127	01760			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01790 SS=F	144G.71 Subd. 10 I residents who will	Medication management for	01790			
	is not able to provide nurse or unlicensed medications in amount the length of the an exceed seven caler (3) the resident must information on medinstructions for administructions for administructions, include (4) the medications medication contained the provider's medication that the residual times that the residual times that the residual times that the registered nunlicensed staff and staff is competent to giving medications (2) the registered nuncipal procedures for the regarding controlled prescribed for the readdress:  (i) the type of contained the provider of the type of the type of the provider of the type of type of the type of type of the type of type o	st be provided written ications, including any special inistering or handling the ing controlled substances; and must be placed in a er or containers appropriate to cation system and must be ident's name and the dates nedications are scheduled. Implications are scheduled, implications are scheduled in the registered nurse may be unlicensed personnel if: urse has trained the determined the unlicensed of follow the procedures for				
	(i) the type of conta for the medications medication system;	appropriate to the provider's				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LLIED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KOMO O	UD HOUGE LLO	204 14TH	ST NW			
KSWS O	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01790	Continued From pa labeled; (iii) written informat	ge 128 ion about the medications to	01790			
	be provided; (iv) how the unlicen the resident's recor	sed staff must document in d that medications have been				
	provided, including documenting the date the medications were provided and who received the medications, the person who provided the					
	medications to the	resident, the number of ere provided to the resident,				
		ed nurse shall be notified that				
	registered nurse ne	een provided and whether the eds to be contacted before				
		e given to the resident or the				
	designated represe	registered nurse of the				
	completion of this to	ask to verify that this task was ely by the unlicensed				
	(vii) how the unlicer	nsed personnel must				
		sident's record any unused				
		e returned to the facility, of each medication and the ned medication.				
	by:	ent is not met as evidenced				
	review, the licenses	ion, interview and record e failed to ensure training and				
	were completed as	itions for preparing ident unplanned times away required for one of one let (ULP-E) with records				
	reviewed.	, , , , , , , , , , , , , , , , , , , ,				
	violation that did no safety but had the p	ed in a level two violation (a but harm a resident's health or cotential to have harmed a				
	resident's nealth or	safety) and was issued at a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01790	Continued From pa	ge 129	01790			
	or represent a syste	when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	ULP-E had a hire d	ate of May 11, 2022.				
		022, at 8:13 a.m. ULP-E was ster medications to R2.				
	registered nurse (R					
	verified ULP were a residents when they	022, at 2:31 p.m. RN-B  ble to send medications with  leave the facility. RN-B  cked training and competency				
	stated, the procedu	sidents was "not in the				
	No further informati	on was provided.				
	TIME PERIOD FOF days	R CORRECTION: Seven (7)				
01820 SS=D	144G.71 Subd. 13 I	Prescriptions	01820			
30-D	recorded prescription	rrent written or electronically on as defined in section 16a, for all prescribed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01820	medications that the managing for the results and the presence orders for medication (R2).  This practice results violation that did no safety but had the president's health or cause serious injury was issued at an issumited number of situation has occurred a limited number of situation has occurred.  The findings includes R2 On September 7, 20 personnel (ULP)-Exmedications to R2.  R2's Medication Add dated September 20 Metamucil powder in beverage and take promote bowels -Systane complete four times daily to be eyes -artificial tears (Visilian).	e assisted living facility is sident.  ent is not met as evidenced on, interview, and record failed to ensure prescriber's ons for one of two residents ed in a level two violation (at harm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death), and plated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).	01820			
	R2's prescriber's or	ders dated June 10, 2022,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01820	Continued From pa	ge 131	01820			
	lacked orders for th	e above medications.				
	nurse (RN)-B stated	2022, at 10:13 a.m. registered d R2's primary physician would ed for clarification of orders.				
	Medication Manage Policy dated June 2 required a prescript treatment services the residents. The fensuring current proprescriber for medical	nesota Delegation of ement and Treatment Services 2020, indicated the company tion for all medication and team members manage for RN was responsible for escriptions from authorized cations and treatments and ered by the team members and sident record.				
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01880	144G.71 Subd. 19	Storage of medications	01880			
SS=F	substantially construction according to the mapermit only authorized. This MN Requirements by:	ations in securely locked and ucted compartments anufacturer's directions and zed personnel to have access.				
	review, the licensee were stored accord	on, interview, and record e failed to ensure medications ing to manufacturer's of one medication refrigerator.				
		ed in a level two violation (a t harm a resident's health or				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
30630 B. WING	09/12/2022
NAME OF PROVIDER OR SUPPLIER  KSMS OUR HOUSE LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW  AUSTIN, MN 55912	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF	R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).  The findings include:  The licensee failed to monitor the temperature of a medication refrigerator to ensure medications were stored according to manufacturer's instructions.  On September 8, 2022, at 9:50 a.m. the refrigerator in the medication closet was observed with unlicensed personnel (ULP)-H. ULP-H confirmed the refrigerator temperature to be 34 degrees Fahrenheit (F) at that time. ULP-H further stated she did not know if there was a monitoring log for recording the temperature of the refrigerator.  The refrigerator contained one or more of the following medications: -glargine (Lantus) insulin pens (used for diabetes/blood sugar control) -aspart (Novolog) insulin pens (used for diabetes/blood sugar control) -Tresiba insulin pens (used for diabetes/blood sugar control)  Manufacturer's instructions for Lantus SoloStar insulin pens dated March 2020, indicated before opening store Lantus in the refrigerator 36 to 46 degrees F.  The manufacturer's instructions provided by the licensee for aspart dated revised November	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	204 14TH	ST NW	STATE, ZIP CODE		
		<u> </u>	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01880	Continued From pa	ge 133	01880			
	2019, indicated to s the refrigerator at 3	tore unused aspart pens in 6 to 46 degrees F.				
	licensee for Tresiba	instructions provided by the revised November 2019, sed Tresiba pens in the 46 degrees F.				
	nurse (RN)-B stated temperature log" for	022, at 9:50 a.m. registered d the licensee had "no r the monitoring the licensee's medication				
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01940 SS=E		dividualized treatment or n	01940			
	ordered or prescribe services, the assiste and include in the statement of the tree that will be provided must also develop a individualized treatmanagement record contain at least the (1) a statement of the provided; (2) documentation or relating to the treatmadministration; (3) identification of the services of the	d for each resident which must following: ne type of services that will be of specific resident instructions				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN,	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01940	(4) procedures for appropriate license problem arises with services; and (5) any resident-spedocumentation of treceived, verification therapy was admin monitoring of treatrossible complication treatment or therapy be current and updichanges.  This MN Requirement by: Based on observation review, the licensed individualized treatment or the presidents (R2, This practice resultiviolation that did not safety but had the president's health or cause serious injurning was issued at a path limited number of rethan a limited number of re	notifying a registered nurse or d health professional when a a treatments or therapy ecific requirements relating to reatment and therapy on that all treatment and istered as prescribed, and ment or therapy to prevent ons or adverse reactions. The y management record must ated when there are any ent is not met as evidenced in a level two violation (a of tharm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and tern scope (when more than a esidents are affected, more or of staff are involved, or the red repeatedly; but is not ve).	01940			

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		30630	B. WING		09/1	2/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS O	KSMS OUR HOUSE LLC 204 14TH						
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	MN 55912	PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
01940	Continued From page 135		01940				
	soft diet.						
	R2's diagnoses included dementia and repeated falls.						
	assessment dated a resident required to and undressing. C-Attempts to take off instructions indicate breakdown due to to C-collar use. May have an old healing "Area will be observapplied for protection be held due to area plan/assessment in eating assistance, reprecaution and meet to remain upright 30 service plan lacked	August 9, 2022, indicated tal assistance with dressing collar used due to fracture. FC-collar. Skin care treatment ed R2 was at risk for skin C-collar. Daily skin check due y 27, 2022, resident noted to blister on top of right big toe. Wed daily and bandaid will be on. Toe guard to right toe will until healed." The service dicated for the service of resident is in aspiration chanical soft diet. Resident is minutes after eating. R2's the treatment services of toe left great toes, Ensure and t.					
	R2's Task Administr September 2022, ir	ration Record dated addicated the same.					
	-dated April 25, 202 mechanical soft die mechanical soft die kitchen for staff edu- dated May 26, 202 noticed a cut on big -dated June 28, 202 bottles for resident. given one time daily	2, when putting on toe guard, I					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	_			
		AUSTIN, N	/N 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 136	01940			
	personnel (ULP)-E medications to R2 a right and left great t	was observed to administer and applied toe guards to R2's coes. The skin on R2's right (no blister was observed).				
	stated the staff were R2 was given "Ensu we push Ensure." A was not sure if R2 w not. ULP-D stated F	022, at 9:28 a.m. ULP-D e monitoring R2's intake and ure supplement. If not eating, at 9:32 a.m. ULP-D stated she was to be wearing C-collar or R2 was on a "mechanical soft neat was shredded, swallows				
	which indicated "die mechanical soft (wh summary was not s -prescriber order da plan to wear collar s Plan a brace wean However, no further	ry print date May 13, 2022, et recommendations - solids: nile on C-collar); however, the signed by a physician. eted June 10, 2022, indicated six weeks then repeat x-ray. potential at that time. Information was provided for egarding if the collar was				
		documented evidence of a or the C-collar, toe guards, nical soft diet.				
	treatment or therap provided to the resi- ensure, mechanical current individualize management recor- toe guards for the fo- a statement of the provided;	cked a written statement of the y services that would be dent (C-collar, toe guards, I soft diet) and lacked a ed treatment and therapy d for the treatment service of ollowing: type of services that will be specific resident instructions				

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING	B. WING		2/2022
NAME OF D	ROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	1 03/1	LIZULL
		204 14TH		STATE, ZIF GODE		
KSMS OU	R HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	will be delegated to procedures for notical appropriate licensed problem arises with services; and any resident-specification that all tradministered as prestreatment or therapy complications or ad On September 7, 20 nurse (RN)-B stated included a current in therapy managemes service of toe guard On September 12, 20 verified there was not guards. At 10:13 a.r. needed to wear the discontinued. [R2] vix weeks only." RN an individualized tremanagement record toe guards, ensure RN-B stated, "I can' Family brought it up weight loss". RN-B mechanical soft die R2's record lacked	atment or therapy tasks that unlicensed personnel; fying a registered nurse or d health professional when a treatments or therapy  fic requirements relating to eatment and therapy received, reatment and therapy was escribed, and monitoring of y to prevent possible verse reactions.  D22, at 10:27 a.m. registered d regarding if R2's record andividualized treatment and nt record for the treatment ls, "No, I don't think so."  D22, at 9:12 a.m. RN-C o prescriber's order for toe m. RN-B stated R2 no longer C-collar. RN-B stated, "It was would not leave it on. It was for l-B verified R2's record lacked eatment and therapy d for the treatment services of and mechanical soft diet. It find an order for it [Ensure]. It and asked us to give it for stated R2 was to receive a term of toe guards, ensure and	01940			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC 204 14TH AUSTIN, I					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01940	Continued From page 138  condition where the pancreas does not produce enough insulin to manage blood sugars), heart failure and intellectual disability.		01940			
	R1's Treatment Pla assessment dated a received treatment sugar checks. R1's dated August 16, 20 Monitoring/Treatme	n integrated into R1's 90-day August 16, 2022, indicated R1 services which included blood s Assessment/Treatment plan 022, in section "Wellness ents" indicated "Is on nd blood sugar checks four				
	On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to check R1's blood sugar.					
	dated August and S "blood glucose chee to 8 times per day" provide blood suga 11:00 a.m., 5:00 p.r designated for PRN	ministration Record (MAR) September 2022, indicated ck (use to test blood sugar) up with scheduled times to r checks daily at 7:00 a.m., m., and 8:00 p.m. and area I medications indicated "blood test blood sugar (BS) up to 8				
	blood sugar checks for supplies of lance	d a prescriber's orders for but, included provider orders ets and alcohol pads (used to for up to eight (8) times daily.				
	R1's Treatment Pla of PRN blood sugar	n lacked the treatment service r checks.				
	a.m. registered nur Treatment plan lack	022 at approximately 10:22 se (RN)-C verified R1's ked revision for providing the discount blood sugar testing.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
	PROVIDER OR SUPPLIER	STREET ADI 204 14TH AUSTIN, N	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01940	Medication Manage Policy dated June 2 develop an individu resident and would for treatment service provide.	nesota Delegation of ement and Treatment Services 2020, indicated the RN would alized treatment plan for each develop specific procedures ses team members would	01940			
01950 SS=D	and therapy  Ordered or prescrib must be administer other licensed health perform the treatmed delegated or assign the licensed health appropriate practice assignment. When or therapy is delegated personnel, the facili registered nurse or professional has:  (1) instructed the upproper methods with the unlicensed personitive to competent (2) specified, in write each resident and on the resident's recitation (3) communicated about the individual	dministration of treatments  and treatments or therapies and by a nurse, physician, or and professional authorized to and to unlicensed personnel by professional according to the and to unlicensed personnel by professional according to the and standards for delegation or administration of a treatment atted or assigned to unlicensed ty must ensure that the authorized licensed health anticensed personnel in the the respect to each resident and and sonnel has demonstrated the aly follow the procedures; aing, specific instructions for documented those instructions and with the unlicensed personnel needs of the resident.  The service of the resident and and the service of the service of the resident.  The service of the s	01950			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
	PROVIDER OR SUPPLIER	STREET AD <b>204 14TH</b>		STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01950	Based on observative review, the license registered nurse (Respecific instructions documented those records for one of the treatments and had personnel in the presonnel in the presonnel (ULP-E, ability to competent violation that did not safety but had the president's health or cause serious injury was issued at an is limited number of real limited number of situation has occurred. The findings included R2's diagnoses included the findings included R2's diagnoses included the findings included resident required to and undressing. C-to fracture. Attempt care treatment instrisk for skin breakd check due to C-coll noted to have an olbig toe. "Area will be will be applied for ptoe will be held due	on, interview and record e failed to ensure an the N) specified, in writing, of for each resident and instructions in the resident's two residents (R2) receiving I instructed the unlicensed oper methods with respect to two of two unlicensed ULP-F) has demonstrated the dy follow the procedures.  The din a level two violation (and tharm a resident's health or cotential to have harmed a safety, but was not likely to by, impairment, or death), and colated scope (when one or a desidents are affected or one or instaff are involved or the red only occasionally).	01950			

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	IES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING	B. WING		2/2022
NAME OF PROVIDER OR SU	IPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
KSMS OUR HOUSE LL	.c	204 14TH AUSTIN,	ST NW MN 55912			
PREFIX (EACH DEI	FICIENC	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
precaution a to remain up service plan guards to rig (supplement R2's Task Ad September 2 R2's observadated April 2 mechanical 3 kitchen for september 3 redated May 2 noticed a curbated June bottles for regiven one time. On September 3 regiven one time. The sk (no blister was not sure not. ULP-D september 3 record in the state of the state	sistance and meaning that and a control and	e resident is in aspiration chanical soft diet. Resident is 0 minutes after eating. R2's the treatment services of toe left great toes, Ensure and mechanical soft diet.  Tation Record dated adicated the same.  The sindicated the following: Particular is now on a set, all foods should be soft. A set guide is hanging in the function.  The system putting on toe guard, I gate.  The system is to be guard, I gate.  The system is the	01950	DEL MOLENOTY		

Minnesota Department of Health

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01950	summary was not s-prescriber order da plan to wear collar and the prescriber's order rediscontinued or not rediscontinued or not R2's record lacked prescriber's order for the ensure and mechan R2's record lacked instructions for the of C-collar (neck browd) (supplement) and not complement) and not complement and the discontinued or not read a hire of C-collar (neck browd) (supplement) and not complement and the discontinued or not read a hire of C-collar (neck browd) (supplement) and not complement and the discontinued or not read a hire of the prescribed of the p	signed by a physician. ated June 10, 2022, indicated six weeks then repeat x-ray. potential at that time. r information was provided for egarding if the collar was documented evidence of a or the C-collar, toe guards,	01950			

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winneso	ta Department of He	aith				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE C	(X5) COMPLETE DATE
01950	mechanical soft die R2's record lacked treatment services and mechanical soft. The licensee's Minr Medication Manage Policy dated June 2 develop an individuresident and would for treatment service provide. The RN we personnel were traiorientated to the respersonnel were to provide to the resperson of the personnel were to provide to the respective to the person of the Medication Admetectronic charting. Include specific det to be performed, the	R2 was to receive a t per orders. RN-B verified specific instructions for the of C-collar, toe guards, ensure it diet.  The specific instructions for the of C-collar, toe guards, ensure it diet.  The specific procedures are to a specific procedures are team members would alized treatment plan for each develop specific procedures are team members would alide ensure unlicensed and, competent, and asident whenever unlicensed before the resident. A RN may revice to unlicensed team and determining that the was trained and competent fucted in the proper methods to be ures with respect to the cluding written instructions for the resident in the eatments were documented on an inistration Record (MAR) in The treatment protocol would alls on how the treatment, structions related to the	01950			
		CORRECT- Seven (7) days.				
01960 SS=D	144G.72 Subd. 5 D administration of tre		01960			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
01960	Each treatment or tassisted living facili record. The docume signature and title of administered the treinclude the date and treatment or therap ordered or prescrib document the reason and any follow-up promeet the resident of the meet the resident of the meet the resident of the meet the resident review, the licensed services were documented from the president (R2).  This practice results violation that did not safety but had the president's health or cause serious injury was issued at an isolimited number of real limited number of situation has occurred the findings included the treatment service (supplement).	herapy administered by an ty must be in the resident entation must include the of the person who eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered procedures that were provided it's needs.  The provider must on the provided it's needs.  The provided it's n	01960			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01960	On September 7, 20 personnel (ULP)-E medications to R2 a right and left great to great toe was intact.  On September 8, 20 stated the staff were R2 was given "Ensure we push Ensure." A was not sure if R2 w (neck brace) or not.  R2's Service Plan in assessment dated a resident required to and undressing. C-Attempts to take off instructions indicate breakdown due to to C-collar use. May have an old healing "Area will be observed applied for protection be held due to area plan lacked the treat to right and left great R2's Task Administr September 2022, in ensure that the resitimes. Please docur C-collar. Has foam taking a shower.  R2's record include -prescriber order daplan to wear collars. Plan a brace wean	D22, at 8:13 a.m. unlicensed was observed to administer and applied toe guards to R2's oes. The skin on R2's right (no blister was observed).  D22, at 9:28 a.m. ULP-D emonitoring R2's intake and are supplement. If not eating, at 9:32 a.m. ULP-D stated she was to be wearing C-collar and assistance with dressing collar used due to fracture. C-collar. Skin care treatment and R2 was at risk for skin C-collar. Daily skin checks due at 27, 2022, resident noted to blister on top of right big toe. Ared daily and bandaid will be on. Toe guard to right toe will until healed." R2's service at the services of toe guards at toes and Ensure.  Tation Record dated addicated C-collar: staff are to dent has C-collar on at all ment here if resident removes collar to change into when	01960			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING	B. WING		2/2022
	PROVIDER OR SUPPLIER	STREET AD <b>204 14TH</b>		STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	AUSTIN, I	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01960	Continued From pa	ge 146	01960			
	prescriber's order rediscontinued or not	egarding if the collar was				
	R2's record lacked documented evidence of a prescriber's order for the C-collar, toe guards, ensure and mechanical soft diet.					
	staff for refusal of C	taff providing the treatment				
	On September 12, 2022, at 10:13 a.m. RN-B stated R2 no longer needed to wear the C-collar. RN-B stated, "It was discontinued. [R2] would not leave it on. It was for six weeks only." At 2:43 p.m. RN-B verified R2's record lacked accurate documentation by staff for refusal of C-collar and lacked documentation of staff providing the treatment service of toe guards and Ensure.					
	Medication Manage Policy dated June 2 were documented of Administration Reco charting. The treatm specific details on h performed, the freq	nesota Delegation of ement and Treatment Services 1020, indicated treatments on the Medication ord (MAR) in electronic nent protocol would include now the treatment was to be uency of the treatment, and tions related to the treatment.				
	No further informati	on was provided.				
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01970 SS=E		reatment and therapy orders	01970			
		p-to-date written or ded order from an authorized				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
01970	prescriber for all tree order must contain description of the tree provided, and the frinformation needed therapy. Treatment renewed at least eventherapy. Treatment renewed at least eventherapy. Treatment renewed at least eventherapy. Based on observation review the licensee order for treatment residents (R2, R1).  This practice results violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited n	eatments and therapies. The the name of the resident, a eatment or therapy to be requency, duration, and other to administer the treatment or and therapy orders must be very 12 months.  The sent is not met as evidenced on, interview, and record failed to ensure a prescriber's or therapy for two of two of the safety, but was not likely to y, impairment, or death) and tern scope (when more than a resident's are affected, more per of staff are involved, or the red repeatedly; but is not ve).	01970			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01970	R2 was given "Ensive push Ensure." A was not sure if R2 not. ULP-D stated F texture" diet and "mbetter."  R2's Service Plan in assessment dated a resident required to and undressing. C-Attempts to take off instructions indicate breakdown due to to C-collar use. May have an old healing "Area will be observapplied for protection be held due to area plan/assessment in eating assistance reprecaution and meet to remain upright 30 service plan lacked guards to right and mechanical soft die R2's Task Administrate September 2022, in and for C-collar staresident has C-collar document here if refoam collar to chan R2's observation not-dated April 25, 202 mechanical soft die	ure supplement. If not eating, at 9:32 a.m. ULP-D stated she was to be wearing C-collar or R2 was on a "mechanical soft leat was shredded, swallows at tegrated into R2's 90 day August 9, 2022, indicated stal assistance with dressing collar used due to fracture. If C-collar. Skin care treatment ed R2 was at risk for skin C-collar. Daily skin check due by 27, 2022, resident noted to a blister on top of right big toe. Wed daily and bandaid will be on. Toe guard to right toe will until healed." The service dicated for the service of esident is in aspiration chanical soft diet. Resident is D minutes after eating. R2's the treatment services of toe left great toes, Ensure and t.  Tration Record dated adicated the same as above ff are to ensure that the ar on at all times. Please esident removes C-collar. Has ge into when taking a shower.  Determine the service of the service of the service of the services of toe left great toes, Ensure and the services of the servic	01970			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
712 . 271	0. 00.11.120.10.1		A. BUILDING:	<del></del>		
		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
K0M0 0	UD HOUGE LLO	204 14TH		,		
KSWS U	KSMS OUR HOUSE LLC AUSTIN,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
01970	Continued From pa	ge 149	01970			
	bottles for resident. given one time daily	22, family did bring Ensure Will request for this to be y. Awaiting doctor orders.				
	R2's record included the following: -After Visit Summary print date May 13, 2022, which indicated "diet recommendations - solids: mechanical soft (while on C-collar); however, the summary was not signed by a physicianprescriber order dated June 10, 2022, indicated plan to wear collar six weeks then repeat x-ray. Plan a brace wean potential at that time. However, no further information was provided for prescriber's order regarding if the collar was discontinued or not.					
		documented evidence of a or the C-collar, toe guards, nical soft diet.				
	nurse (RN)-C verific order for toe guards R2 no longer needs stated, "It was disco it on. It was for six verified an order f it up and asked us	2022, at 9:12 a.m. registered ed there was no prescriber's s. At 10:13 a.m. RN-B stated ed to wear the C-collar. RN-B ontinued. [R2] would not leave weeks only." RN-B stated, "I for it [Ensure]. Family brought to give it for weight loss". s to receive a mechanical soft				
	condition where the enough insulin to m failure and intellect	•				
		n integrated into R1's 90-day August 16, 2022, indicated R1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH	ST NW VIN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
01970	Continued From pa	ge 150	01970			
	sugar checks. R1's dated August 16, 20 Monitoring/Treatme	services which included blood s Assessment/Treatment plan 022, in section "Wellness ents" indicated "Is on nd blood sugar checks four (4)				
		022, at approximately 11:00 served to check R1's blood				
	R1's Medication Administration Record (MAR) dated August and September 2022, indicated "blood glucose check (use to test blood sugar) up to 8 [eight] times per day" with scheduled times to provide blood sugar checks daily at 7:00 a.m., 11:00 a.m., 5:00 p.m., and 8:00 p.m. and area designated for PRN medications indicated "blood sugar check-use to test blood sugar (BS) up to 8 [eight] times per day."					
	blood sugar checks for supplies of lance	d a prescriber's orders for but, included provider orders ets and alcohol pads (used to for up to eight (8) times daily.				
	a.m. registered nurs	022, at approximately 10:22 se (RN)-C verified R1's record ders to include blood sugar				
	Medication Manage Policy dated June 2 required a prescript treatment services the residents. The F ensuring current pro prescriber for medical	nesota Delegation of ement and Treatment Services 2020, indicated the company tion for all medication and team members manage for RN was responsible for escriptions from authorized cations and treatments and ered by the team members and				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30630	B. WING		09/12/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
TW TWIL OT T	NOVIDER OR GOLF EIER	204 14TH		57/11 CODE		
KSMS O	UR HOUSE LLC		MN 55912			
0(1) ID	CLIMMA DV CTA			DDOV/DEDIS DI ANI OF CODDECTIO	N.	()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	DATE
				DEFICIENCY)		
01970	Continued From pa	ge 151	01970			
	were kept in the res	sident record				
	were kept in the res	sident record.				
	No further informati	ion was provided				
	Tro Iditator Illionida	ion nao providoa.				
	TIME PERIOD FOR	R CORRECTION: Seven (7)				
	days					
	144G.82 Subd. 3 P	olicies	02110			
SS=F						
	(a) In addition to the policies and procedures					
	•	nsing of all facilities, the				
		ty with dementia care licensee				
		mplement policies and				
	procedures that add					
		ow services are provided sisted living facility licensee's				
	values, mission, an					
		are and how the philosophy				
	shall be implemented					
		havioral symptoms and				
		for intervention plans,				
		nacological practices that are				
	•	nd evidence-informed;				
		egress prevention that				
	•	structions to staff in the event				
	a resident elopes;	anamant including an				
		agement, including an dents for the use and effects				
	of medications, incl					
	medications;					
		ecific to dementia care;				
	(6) description of lif	e enrichment programs and				
	how activities are in	•				
		mily support programs and				
	efforts to keep the f					
		of public address and				
		or emergencies and				
	evacuation drills on					
	(a) transportation c	oordination and assistance to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/	12/2022
	PROVIDER OR SUPPLIER UR HOUSE LLC	STREET ADI 204 14TH AUSTIN, N	ST NW	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
02110	and from outside m (10) safekeeping of (b) The policies and to residents and the designated represe move-in.  This MN Requireme by: Based on interview licensee failed to de required policies and dementia care and and procedures to r legal and designate of move-in.  This practice result violation that did no safety but had the p resident's health or cause serious injury is issued at a wides are pervasive or rep	edical appointments; and residents' possessions. If procedures must be provided e residents' legal and intatives at the time of ent is not met as evidenced and record review, the evelop and implement all id procedures related to failed to provide the policies residents and the residents' id representatives at the time ent all tharm a resident's health or potential to have harmed a safety, but was not likely to y, impairment, or death), and ipread scope (when problems present a systemic failure that the potential to affect a large	02110			
		censed as an Assisted Living				
	The licensee lacked procedures related - philosophy of how based upon the ass values, mission, an person-centered cabe implemented;	services are to be provided sisted living facility licensee's				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02110	of supports for inter that includes nonphare person-centere - medication managassessment of residual of medications assessment of residual psychotropic medicity of medications are implered activities and from outside medication and designated representation activities are implemented activities are implered activities are implemented activitie	rvention plans. Lacks content parmacological practices that d and evidence-informed; gement, including an dents for the use and effects its content that includes sations; iffic to dementia care; genrichment programs and how mented; ily support programs and ily engaged; public address and intercomencies and evacuation drills; ordination and assistance to redical appointments; and sidents' possessions  to provide policies and ents and the residents' legal resentative at the time of  2022, at approximately 9:30 red living director (LALD)-A red (RN)-B stated they were not specific policies. LALD-A were difficult to find within their is system. With review of missing content, LALD-A and rould have to inquire further. Some content of some of the led in the contract and/or a ven to residents and their me of admission.	02110			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		00/40/0000	
		30630			09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	SI NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02260 SS=C	An assisted living far make available in water residents and familiar request it, a description and related training categories of employs training, and the base copy of this notice request.  This MN Requirements by: Based on interview licensee failed to intraining program for electronic form to repersons who request.  This practice results violation that has not a minimal impact of	otice of dementia training acility with dementia care shall vritten or electronic form, to ites or other persons who otion of the training program it provides, including the oyees trained, the frequency of sic topics covered. A hard must be provided upon  ent is not met as evidenced and record review, the clude a description of the residents, families, or other st it, with records reviewed.  ed in a level one violation (a potential to cause more than in the resident and does not ety), and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of ecategories of employees may of training, and the basic indicated "Consumer or electronic form a sining program, the categories frequency of training and the	02260			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		<u> </u>
KSMS O	UR HOUSE LLC	204 14TH	_			
AUSTIN, I			MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
02260	Continued From page 155		02260			
	basic topics covered." The information lacked a description of the training program (how the training was provided).					
	On September 8, 2022, at 2:27 p.m. registered nurse (RN)-C stated, "No" the licensee did not have a notice of dementia. RN-C stated the licensee was "working on that, brought up a month ago". RN-C stated, "The information was sent to the Ombudsman [a person who investigates, reports on, and helps settle complaints] for final approval, because they are the one that requested it."  On September 12, 2022, at 9:12 a.m. licensed assisted living director (LALD)-A stated the information in the licensee's Resident and Services Agreement the "Dementia Specific Training" was the dementia notice.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One					
02310 SS=G	(a) Residents have living services that a resident's needs an	ppropriate care and services the right to care and assisted are appropriate based on the daccording to an up-to-date to accepted health care	02310			
	by: Based on observati review, the licensee services were provi	on, interview, and record failed to ensure care and ded according to acceptable dical, or nursing standards				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILDING.			
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02310	with bedrails/side ra (R2) with record revimmediate correction 2022, at 1:15 p.m.  This practice result violation that harmonot including serious or a violation that has serious injury, impaissued at an isolate limited number of ra limited number of situation has occurred a limited number of situation has occurred a limited number of situation has occurred a limited number of situation has occurred in the findings included R2's Resident Infor September 7, 2022 unspecified demendiaturbance.  R2's record identified a Restrictive Proceed dated August 12, 20 device was quarter repositioning bar, the assistive device preceding events a triggered the symptop bed," underlying can "dementia" and indicated R2 would responsible paindicated R2 would	ails for one of one resident viewed. This resulted in an on order on September 7, and a resident's health or safety, is injury, impairment, or death, as the potential to lead to a sidents are affected or one or a staff are involved or the red only occasionally).  The control of the following:  The control of the red only occasionally of the symptom was being considered for and conditions that nay have som: "numerous falls out of use of the symptom was facted "no risk with positioning resident will be able to position alle in bed."  The greement dated and signed by arty on February 9, 2022, like to use the grab bar to turn sleeping hours for positioning,	02310			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
71101 1711	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			LETED
			D WING			
		30630	B. WING		09/1	2/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	KSMS OUR HOUSE LLC					
1101110 0	OK HOUSE EES	AUSTIN, M	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 157	02310			
	aware of the purpos	se of the bar and had been ential risks involved with its ossibility of becoming				
	personnel (ULP)-E medication to R2 in observed to have a	022, at 8:13 a.m. unlicensed was observed to administer R2 room. R2's bed was grab bar (physical assist the upper right side of the				
	On September 7, 2022, at 10:27 a.m. registered nurse (RN)-B denied having the manufacturer instructions for R2's grab bar device. RN-B stated, "no, it was brought in by family" and was in place "before I got involved."					
	On September 7, 2022, at 11:20 a.m. R2's bed was observed with RN-B to have a grab bar device in place on the upper right side of R2's bed. The grab bar device was attached to a board and the board was placed between the mattress and the bed frame of R2's bed. On the board was a sticker which identified "Mobility Transfer System Inc. Model #501."					
	manufacturer instru	documented evidence of actions for the grab bar device, vidence if there was a recall for				
	surveyor requested manufacturer instru	022, at 12:08 p.m. the RN-B to provide the actions and whether the grab alled. RN-B stated she would be was a recall.				
		022, at 12:30 p.m. RN-C or with the manufacturer				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30630	B. WING		09/12/2022	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	09/1	212022
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	ST NW			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	instructions for the "I called the compa are not aware of re been sold a couple  The Consumer Pro (CPSC) Urges Con Use of Mobility Trai Bed Rails Due to E Hazard; Three Dea June 2, 2022, for F CPSC's warning ap rails. The bed rails by Mobility Transfel	grab bar device. RN-C stated, ny" (for grab bar device), "they call, but the company has of times."  duct Safety Commission sumers to Immediately Stop asfer Systems Adult Portable antrapment and Asphyxia ths Reported release date reedom Grip Model 501. Splies to 10 models of bed were manufactured and sold Systems Inc. from 1992 to Tubing USA Inc. in 2021 and	02310			
02480 SS=D	On September 8, 2 immediacy was ren correspondence wi non-compliance ren TIME PERIOD FOR days  144G.91 Subd. 20  Residents have the timely response to limitation. Resident every facility must pinformation of the p	Grievances and inquiries  right to make and receive a a complaint or inquiry, without s have the right to know and provide the name and contact person representing the facility to handle and resolve	02480			

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NAME OF PROVIDER OR SUPPLIER  KSMS OUR HOUSE LLC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912  (X5)	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (R2).  This practice resulted in a level two violation (a violation that did not harm 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				A. BOILDING.			
CX4) ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   This MN Requirement is not met as evidenced by:   Based on interview and record review, the licensee failed to respond to grievances of one of one resident (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   IDD   PROVIDER'S PLAN OF CORRECTION (X5) (X5) (COMPLETE DATE			30630	B. WING		09/1	2/2022
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  02480 Continued From page 159  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (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	NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)  O2480  Continued From page 159  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (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	KSMS O	UR HOUSE LLC		_			
This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
The findings include:  On September 6, 2022, at approximately 10:27 a.m. the surveyor requested the licensee's grievances.  The licensees' grievances included a handwritten note dated May 1, 2022, and an undated handwritten note for concerns regarding R2.  The note dated May 1, 2022, indicated R2 was transported to hospital for a fractured vertebra and more images needed to be taken because they think there may be more fractures. A family member expressed concern to the doctor about R2 returning to the facility because the facility was understaffed and R2 needs one to one care. The guardian of R2 expressed concerns about R2's doctor. The guardian informed the doctor she had no concerns about R2 returning to the facility.	02480	This MN Requirements: Based on interview licensee failed to recone resident (R2).  This practice result violation that did no safety but had the president's health or cause serious injury was issued at an islimited number of real limited number of situation has occurr.  The findings include On September 6, 2 a.m. the surveyor regrievances.  The licensees' grieve note dated May 1, 2 handwritten note for the note dated May 1, 2 handwritten note for the note dated May 1, 2 handwritten note for the note dated May 1, 2 handwritten note for the purpose of R2 returning to the was understaffed a The guardian of R2 R2's doctor. The guardian of R2 R2's doctor. The guardian occoncerning to the date of R2 R2's doctor. The guardian of R2 R2's doctor. The guardian occoncerning to the date of R2 R2's doctor. The guardian of R2 R2's doctor. The guardian occoncerning to the date of R2 R2's doctor. The guardian of R2 R2's doctor.	and record review, the spond to grievances of one of ed in a level two violation (a tharm a resident's health or obtential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).  E:  O22, at approximately 10:27 equested the licensee's  Vances included a handwritten 2022, and an undated r concerns regarding R2.  y 1, 2022, indicated R2 was ital for a fractured vertebra eeded to be taken because y be more fractures. A family concern to the doctor about facility because the facility and R2 needs one to one care. expressed concerns about lardian informed the doctor	02480			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02480	or walker, the TV siciothing concern for be in on Halloween On September 8, 2 nurse (RN)-B provinguardian on May 3, nurse (LPN)-G indictional staff (nurse been determined R continue to be safe staffing to meet this for safety would be receive one to one where she can rece concerns are she may restlessness and us one to one care. As requires one to one to accept her back R2's record lacked grievances or attem On September 8, 2 she had no other in grievances.  The licensee's Griepolicy dated Januar resident, guardian, representative may with our company. The receipt of the grieval involved regarding conclusion. After rearea director, a representative, a representative may are a director, a representative rearea director, a representative rearea director, a representative rearea director, a representative may are a director, a representative rearea director.	naving no glasses, hearing aid nows R2 was watching and relothing R2 was supposed to 22, at 12:54 p.m. registered ded an email sent to R2's 2022, from licensed practical cating after speaking with the e and social worker) it has 2 needs one to one in order to 3. The facility does not have a need. My recommendation, to keep her where she can care or place her in a facility give one to one care. My nay fall again due to increased a unable to adequately staff a soon as she no longer a staffing, we would be happy	02480			

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IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE COMP	
		A. BUILDING:			
	30630	B. WING		09/1	2/2022
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
UR HOUSE LLC		_			
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	_D BE	(X5) COMPLETE DATE
Continued From pa	ge 161	02480			
the findings, and th taken would be pro resident's guardian	e conclusions and any actions vided to the resident, , agent, or designated				
No other informatio	n was provided.				
TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-One				
626.557 Subd. 3 Ti	ming of report	03000			
believe that a vulne been maltreated, or vulnerable adult ha which is not reason immediately report common entry poin vulnerable adult so admitted to a facility required to report s individual that occu unless:  (1) the individual wa another facility and believe the vulneral previous facility; or  (2) the reporter knothat the individual is in section 626.5572  (a), clause (4).  (b) A person not recording provisions of this section described above.  (c) Nothing in this section will be adult the section of the section of the section of the section of this section of the third of the third of this section of the third of this section of this section of the third of this section of this section of the third of this section of the third of this section of this	erable adult is being or has a who has knowledge that a se sustained a physical injury ably explained shall the information to the t. If an individual is a lely because the individual is y, a mandated reporter is not suspected maltreatment of the rred prior to admission, as admitted to the facility from the reporter has reason to be adult was maltreated in the lows or has reason to be be a vulnerable adult as defined 2, subdivision 21, paragraph quired to report under the section may voluntarily report as section requires a report of				
	PROVIDER OR SUPPLIER  UR HOUSE LLC  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa the findings, and th taken would be pro resident's guardian representative and resident's record.  No other information  TIME PERIOD FOR (21) Days  626.557 Subd. 3 Ti  (a) A mandated rep believe that a vulne been maltreated, or vulnerable adult ha which is not reason immediately report common entry poin vulnerable adult so admitted to a facility required to report s individual that occu unless: (1) the individual wa another facility and believe the vulneral previous facility; or (2) the reporter kno that the individual is in section 626.5572 (a), clause (4). (b) A person not rec provisions of this se described above. (c) Nothing in this se known or suspecter	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 161  the findings, and the conclusions and any actions taken would be provided to the resident, resident's guardian, agent, or designated representative and shall be placed in the resident's record.  No other information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) Days  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	PROVIDER OR SUPPLIER  30630  STREET ADDRESS, CITY, \$ 204 14TH ST NW AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 161  the findings, and the conclusions and any actions taken would be provided to the resident, resident's guardian, agent, or designated representative and shall be placed in the resident's record.  No other information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) Days  626.557 Subd. 3 Timing of report  (a) A mandated reporter who has reason to believe 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	PROVIDER OR SUPPLIER  30630  STREET ADDRESS, CITY, STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 55912  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 161  Continued From page 161  O2480  Continued From page 161  Continued From page 161  O2480  O	OF CORRECTION    IDENTIFICATION NUMBER:   A BUILDING:

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		20620	B. WING		00/4	2/2022
		30630	l		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN. I	SI NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	been made to the of (d) Nothing in this is reporter from also ragency.  (e) A mandated represson to believe the 626.5572, subdivisity (5), occurred must subdivision. If the rebelieves that an invinvestigative agency determine that the according to the crisubdivision 17, parareporter or facility nentry point or direct agency information meets the criteria usubdivision 17, paralead investigative a information when make the report under sure the report under sure This MN Requirements.  This MN Requirements (MAARC) suspected complete a thorougy occurrences of sus three residents (R3). This practice result violation that harmonot including serious or a violation that his serious injury, impaissued at a pattern	common entry point. section shall preclude a reporting to a law enforcement forter who knows or has not an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any time restigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, ragraph (c), clause (5), the may provide to the common restigation has the event restigation of the event restigation of 26.5572, regraph (c), clause (5). The restigation for pected abuse and failed to reported error was not neglect restigation of the common restigation of the event restigation of the event restigation for rected abuse for three of	03000			

Minnesota Department of Health

STATE FORM 6899 Y97111 If continuation sheet 163 of 169

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		00/4	2/2022
NAME OF					09/1	2/2022
	PROVIDER OR SUPPLIER	204 14TH		STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 163	03000			
		per of staff are involved, or the red repeatedly; but is not ve).				
	The findings include	e:				
	of resident to reside sexual) and lacked	d immediate report to MAARC ent altercations (physical and evidence of documentation of ation of staff and resident to the altercations.				
	R3's diagnoses incl loss).	uded dementia (memory				
	following: -dated August 8, 20 resident altercation walker at resident # follow up actions: R	nt Reports included the 121, indicated resident to Resident #1 (R2) threw her 12 (R3). Other outcome and resident shows no injury from se asked him about it, R3 me".				
	resident altercation #12 [R3] were in the #16 asked R3 if he women (referring to getting aggressive a started hitting R3 w and follow up action incident the two res Resident shows no cane. Staff would si staff noticed residen	2021, indicated resident to Resident #16 and resident be back living room. Resident was sleeping with those staff). Resident #16 was and agitated. Resident #16 ith her cane. Other outcome has: per staff interviews from idents were separated. injury from being hit with the eparate the residents when hat #16 becomes agitated.				
		. Staff entered resident #16's				

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	ST NW MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	[R3] was in resident had R3's genitals in leave resident #16's follow up actions: reincident. Resident # close relationship staff observation the from both residents (POA) was contacted was ok as long as the relationship was ok needed due to all perelationship between dated September resident altercation peacefully in the froughling at him and the stepped in between were able to be reduced to the eating on her. Referred was okneeded to be reduced to the resident was okneeded due to all perelationship between were able to be reduced to the resident altercation peacefully in the froughling at him and the stepped in between were able to be reduced to the resident was the resident's if needed to t	d glucose test. Resident #12 t #16's room. Resident #16 her mouth. Staff asked R3 to s room. Other outcome and esident shows no injury from #16 and R3 have had a very ince she was admitted. From is relationship is consensual . Residents' power of attorney ed and agreed relationship both resident parties agree the . Staff would intervene if arties not agreeing yet to en the two residents.  10, 2021, indicated resident to Resident #12 [R3] was sitting ent when resident #16 started ried to lunge at him. This writer and called for help. Resident irected and altercation ome and follow up actions: per t #16 has been accusing R3 of esident #16 becomes very inks this and at times does ith resident. Staff continue to and intervene and separate reded.  d the following MAARC  mitted Wed. September 1, Indicated on August 30, 2021, d resident #16 have engaged ship with one another. Staff exual act between the two dents have consented to the residents' POAs are aware of I have agreed they may	03000			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30630	B. WING		09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH Austin	ST NW MN 55912			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
03000	Continued From pa	ge 165	03000			
	nurse (RN)-B stated reports for the above altercations. RN-B stated resident #16) had a was unable to ident she would have to I regarding the above However, no further R2 The licensee lacked of a thorough investigation resident interviews unknown origin to describe R2's diagnoses included R2's MAARC report Thursday, February indicated on February	t, date and time submitted 24, 2022, at 12:56 p.m. ary 23, 2022, at 2:00 p.m. R2				
	around bra strap lin and follows a straig measures 3 centime denies any abuse. I February 15, 2022, bruising. Concern F to bruise (complete and R2 stated "I do	a bruise to left clavicle area e. Area was yellow in color ht line along bra strap. Bruise eters (cm) x 0.6 cm. R2 R2 noted to have fall on that may have caused this Regarding a Resident Update ) identified R2 was interviewed n't know" to the questions				
	you. An Injury or Bi Investigation dated on February 15, 200 via ambulance. Are belt. R2's record lad documentation of in	I you fall and did someone hurt ruise of unknown Origin February 23, 2022, indicate 22, resident was transferred a of bruising matches with cot cked evidence of a terviews completed with the ther residents to determine if				

Minnesota Department of Health

WIIIIII	na Department of Tie	ailii				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COIVIE	LETED
		30630	B. WING		09/1	2/2022
					1 09/1	2/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	_			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
03000	Continued From pa	ge 166	03000			
	verified R2's record documentation of ir	022, at 10:46 a.m. RN-B lacked evidence of sterviews completed with the other residents to determine if				
	of injury of unknown of documentation of staff, resident and of	d immediate report to MAARC norigin and lacked evidence f a thorough investigation of other resident interviews of unknown origin to occurred.				
	R4's diagnoses incl	uded dementia.				
	R4's MAARC report, date and time submitted Thursday, May 26, 2022, at 9:40 a.m. indicated on May 21, 2022, at 8:55 p.m. R4 was noted to have a swollen right arm/hand and the area was painful with range of motion. The nurse on call instructed to send R4 to the ER. It was found the resident had a broken right elbow. R4 was noted to have a fall on May 19, 2022, but showed no signs of pain at the time of the fall or after. A Concern Regarding a Resident Concern note dated May 21, 2022, indicated at 3:00 p.m. this evening staff noticed "resident's arm had gotten bigger than yesterday." Resident was able to squeeze staffs hand. During supper time staff noticed "residents arm got more bigger." Unable to squeeze staff hands, unable to see her knuckles, purple and warm to touch. Staff called on call nurse around 8:20 p.m. and informed about resident's arm. Resident was transferred to ER.					
		022, at 10:46 a.m. RN-B t sure why" the R4's injury was				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30630	B. WING		09/1	2/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 167	03000			
		ARC. RN-B stated that's "all I cumented information of R4's /e.				
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
03090 SS=C	144.6502, Subd. 8 I	Notice to Visitors	03090			
	a sign at each facility visitors that states: devices, including s	sitors. (a) A facility must post ty entrance accessible to "Electronic monitoring ecurity cameras and audio esent to record persons and				
		sponsible for installing and nage required in this				
	by: Based on observati failed to ensure the the main entry way statutory language t monitoring activity,	ent is not met as evidenced on and interview, the licensee required notice was posted at of the establishment to display to disclose electronic potentially affecting all current isted living facility, staff and censee.				
	violation that has no a minimal impact or affect health or safe widespread scope ( or represent a syste	ed in a level one violation (a of potential to cause more than the resident and does not ety), and was issued at a when problems are pervasive emic failure that has affected affect a large portion or all of				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY. STATE, ZIP CODE  204 14TH ST NW AUSTIN, MN 59912  (PAPI)  PROVIDERS PLAN OF CORRECTION  (EACH CORRECT ON MISTE EPISCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  DISPIPATION  ON September 6, 2022, at approximately 10:00 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting of selectro (LALD)-A, LALD-A confirmed there was no posted information outside the front entrance regarding electronic monitoring devices.  On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed there was no posted information outside the front entrance regarding electronic monitoring devices. LALD-A stated, "That, I did not know", regarding the requirement.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
KSMS OUR HOUSE LLC  204 14TH ST NW AUSTIN, MN 55912  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  03090  Continued From page 168 the residents).  The findings include:  On September 6, 2022, at approximately 10:00 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices.  On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed there was no posted information outside the front entrance regarding electronic monitoring devices. LALD-A stated, "That, I did not know", regarding the requirement.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One			30630	B. WING		09/1	2/2022
(XA) ID PREFIX TAG  (XA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (XB) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMMLETE DATE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (XB) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  (CROSS-REFERENCED TO THE APPROPRIATE DATE  (CRO	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CX4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PROVIDER'S PLAN OF CORRECTION COMPLETE DEFICIENCY)      03090   Continued From page 168   the residents).   The findings include:   On September 6, 2022, at approximately 10:00 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices.   On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed there was no posted information outside the front entrance regarding electronic monitoring devices. LALD-A stated, "That, I did not know", regarding the requirement.   No further information was provided.   TIME PERIOD FOR CORRECTION: Twenty-One	KSMS O	UR HOUSE LLC					
the residents).  The findings include:  On September 6, 2022, at approximately 10:00 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices.  On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed there was no posted information outside the front entrance, or just inside the front entrance regarding electronic monitoring devices. LALD-A stated, "That, I did not know", regarding the requirement.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
	03090	the residents).  The findings included on September 6, 2 a.m. upon arriving a observation outside inside the front entroposting for electron.  On September 6, 2 p.m. during observativing director (LALI was no posted information entrance, or just instead, "That, I did in requirement.  No further information.	e: 022, at approximately 10:00 at the establishment, an the front entrance, or just rance, lacked the required ic monitoring devices. 022, at approximately 2:03 ation with licensed assisted D)-A, LALD-A confirmed there rmation outside the front side the front entrance c monitoring devices. LALD-A not know", regarding the ion was provided.	03090			



Type: Full Date: 09/07/22

Time: 11:24:24 Report: 7920221194

## Food and Beverage Establishment Inspection Report

Page 1

#### Location:

Ksms Our House Llc 204 14th St Nw Austin, MN55912 Mower County, 50

### Establishment Info:

ID#: 0037699

Risk:

Announced Inspection: No

#### License Categories:

Expires on: //

#### **Operator:**

Phone #: 5074372179

ID #:

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

No NEW orders were issued during this inspection.

#### **Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit

Location: Spray bottle Violation Issued: No

Quaternary Ammonia: = 300 ppm at Degrees Fahrenheit

Location: Spray bottle Violation Issued: No

Hot Water: = at 190 Degrees Fahrenheit

Location: Dishwasher Violation Issued: No

#### **Food and Equipment Temperatures**

Process/Item: Upright Cooler

Temperature: 34 Degrees Fahrenheit - Location: Milk,

Violation Issued: No

Process/Item: Upright Freezer

Temperature: -20 Degrees Fahrenheit - Location: Juice, cool whip, waffels

Violation Issued: No

Process/Item: Upright Freezer

Temperature: -2 Degrees Fahrenheit - Location: Burger patties, bread

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 32 Degrees Fahrenheit - Location: Milk, salad dressing

Violation Issued: No

Page 2

Type: Full
Date: 09/07/22
Time: 11:24:24
Report: 7920221194

Ksms Our House Llc

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 7920221194 of 09/07/22.

Certified Food Protection Manager:		-
Certification Number:	Expires:/ /	
Signed:  Malika Jeffers	Signed: Sam B	oysen

Public Health Sanitarian Rochester District Office 507-206-2719

samuel.boysen@state.mn.us