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).

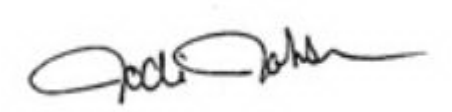
Please address your cover letter for reconsideration requests to:

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30630 | A. BUILDING: _____ B. WING _____ | R 04/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KSMS OUR HOUSE LLC | 204 14TH ST NW AUSTIN, MN 55912 |

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| {0 000} | Initial Comments<br><br>*****ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>Project SL30630015-2<br><br>On April 4, 2023, through April 5, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 11, 2023. At the time of the survey, there were 16 residents: 16 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued. | {0 000} | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| {0 800} SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including | {0 800} | | |

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| {0 800} | Continued From page 1<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 800} | | |
| {01640} SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced | {01640} | | |

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| {01640} | Continued From page 2 | {01640} | | |

by:
Based on interview and record review, the licensee failed to ensure the service plan was revised with changes in services for one of three residents (R8).

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

The findings include:

The licensee lacked revision of R8's service plan for the treatment service of as needed (PRN) blood sugar checks.

R8's diagnoses included type two diabetes and dementia.

R8's prescriber order dated January 17, 2023, included an order for blood glucose check PRN.

R8's Medication Administration Record dated April 2023, identified "Blood Glucose Check. Check blood sugar as needed for hypoglycemia symptoms (low blood sugar symptoms- irritability, shakiness, confusion, light headedness). Give resident a glass of juice if below 70 and then call nurse on call for further instruction."

R8's Service Plan integrated into R8's MN Assessment, Care and Treatment Plan was dated February 13, 2023. R8's service plan indicated R8 received services including reminder for

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| {01640} | Continued From page 3<br>eyeglasses/use of walker, fall risk monitoring, dressing/grooming reminders, assist with toileting, bathing, wellness monitoring, compassionate touch, medication management, meals, housekeeping and orientation. R8's service plan did not include PRN blood glucose checks.<br><br>On April 5, 2023, at 3:18 p.m. registered nurse (RN)-C verified the residents service plan and assessments were integrated into R8's MN Assessment, Care and Treatment Plan dated February 13, 2023, and stated the treatment of blood glucose check PRN was not included.<br><br>The licensee's MN Service Plan Content Policy dated revised June 2020, indicated all residents/tenants have an up-to-date service plan identifying services to be provided based on the assessment by the RN.<br><br>No further information was provided. | {01640} | | |

DEPARTMENT OF HEALTH

*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):

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 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division

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

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**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. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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**

**Minnesota Department of Health**
**Health Regulation Division**

PMB

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| {0 000} | Initial Comments<br><br>*****ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>Project SL30630015<br><br>On January 9, 2023, through January 11, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 9, 2022. At the time of the survey, there were 14 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. | {0 000} | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| {0 620} SS=E | 144G.42 Subd. 6 (a) Compliance with requirements for reporting ma<br><br>144G.42 Subd. 6. Compliance with requirements | {0 620} | | |

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| {0 620} | Continued From page 1<br>for reporting maltreatment of vulnerable adults; abuse prevention plan.<br>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse for two of two residents (R9, R1).<br><br>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).<br><br>The findings include:<br><br>The licensee lacked immediate report to MAARC of staff to resident physical and verbal abuse.<br><br>R9<br>R9's diagnoses included dementia.<br><br>R9's MAARC report identified estimated date of incidence was November 8, 2022. A description of the incident indicated an unlicensed personnel | {0 620} | | |

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| {0 620} | Continued From page 2 | {0 620} | | |

(ULP) reported she saw ULP-J forcing R9 back into her wheelchair by her shoulders and told R9 to "shut up". R9 was not able to confirm or deny. ULP also stated she heard ULP-J telling R9 to shut up during one of her behaviors. There were no other witnesses. "This staff member [ULP-J] was suspended that day and no longer works here."

The MAARC Form identified Date/Time Submitted was Tuesday November 15, 2022, at 3:59 p.m. (seven days after date of incidence occurred on November 8, 2022).

R1
R1's diagnoses included dementia.

R1's MAARC report identified the estimated date of incidence was November 8, 2022. A description of the incident indicated R1 was wanting more coffee and ULP-J ignored him for a minute and then told him to "shut up" and she would get some in a minute. This was the statement provided by a staff person. "This nurse is seeing this report for the first time today. Assistant director had taken [ULP-J] off of the schedule while she completed the investigation. [ULP-J] no longer works here. November 8, 2022, was the last time she was in the facility."

The MAARC Form identified Date/Time Submitted was Tuesday November 15, 2022, at 4:16 p.m. (seven days after date of incidence occurred on November 8, 2022).

Investigation Summary event date November 9, 2022, indicated date and time November 9, 2022, at 8:15 a.m. assistant director reported to work and found multiple notes on her desk. The first note read "11/8/22 [ULP-J] is really mean to

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| {0 620} | Continued From page 3 | {0 620} | | |

residents. She yells at [R1] and [R9] and tells them to shut up. When the residents ask for more food she either ignores them or tells them they cannot have anymore." "This note was written by resident care assistant (RCA) [ULP-K]." "The second note reads: [ULP-J] is very rude to the residents. I heard her tell [R1] to shut up when he asked for more coffee. She also told [R9] to shut up during one of her behaviors. When [R9] was standing up I saw [ULP-J] grab [R9] by the shoulders and force her down into her wheelchair. This was also dated 11/8/22 written by RCA [ULP-L]." The Investigation Summary further indicated on November 15, 2022, "VA [vulnerable adult] report was completed."

On January 9, 2022, at 2:01 p.m. registered nurse (RN)-C stated, "We became aware" of the incidences above "on November 9". "Staff left random notes. We had to do an investigation. I was off a few days between. I realized they should of been filed days ago. I waited until investigation notes came back to us." RN-C stated the former licensed assisted living director (LALD-A) said to wait with reporting (filing a MAARC report). RN-C stated we educated staff and informed staff "call, no notes."

The licensee's Reporting Resident/Tenant Abuse, Neglect, Stealing, Etc. Policy revised April 2022, indicated team members who suspect or have witnessed questionable activities (physical) or communication (verbal or written) of another resident/tenant, caregiver or other team member, visitor, or non-caregiver are required to report the suspicions to the director or other management staff immediately and confidentially, regardless of if they have all the facts or are unsure of their feelings or assumptions. The policy further indicated the state of Minnesota requires

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| {0 620} | Continued From page 4<br>reporting immediately, regardless of the facts, by the director or assistant director to the MAARC any unexplained injuries, which are defines as if a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained.<br><br>No further information was provided. | {0 620} | | |
| {0 660} SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. | {0 660} | | |

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| {0 660} | Continued From page 5 | {0 660} | | |

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

The findings include:

The licensee's TB facility risk assessment dated November 11, 2022, indicated the licensee was a low risk.

TB POLICY
The licensee's Minnesota TB Prevention Control Policy dated December 2022, indicated administrative responsibility for TB infection control program: The "RN" (registered nurse) was responsible for establishing and maintaining the TB prevention and control program. Responsibilities include: 5. Educate assisted living staff and contracted staff volunteers if applicable regarding TB signs and symptoms, our infection control plan, and other communicable diseases.

The policy did not address when health care worker (HCW) education for TB should be conducted and the content of TB education above did not include the topic of TB pathogenesis and transmission.

TB PLAN/EDUCATION
The licensee's Minnesota TB Prevention Control Policy dated December 2022, included "8. if a case of suspected or confirmed TB is identified among staff or residents, assure appropriate

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| {0 660} | Continued From page 6 | {0 660} | | |

actions will be taken immediately, which may include assistance with arrangement for transfer of the resident to an inpatient facility while collaborating and cooperating with local and public health and MDH. 9, If a case of suspected or confirmed TB is not promptly recognized and addressed, identify why and take steps to change the plan or do additional training to assure it will be promptly addresses in the future."

The licensee lacked a written TB infection control plan for the procedures to address isolation and referral according to MDH guidelines as below for isolation and referral; therefore, none of the licensee's employees had received training on their role in the procedure.

On January 11, 2022, at 2:12 p.m. licensed assisted living director (LALD)-B reviewed the licensee's TB policy and stated "okay" regarding the licensee's policy lacked procedures to address isolation and referral.

The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should have an up-to-date TB infection control program that included: Written TB infection control procedures; Health care worker (HCW) education. TB training is required at time of hire for all HCWs. The content of the training should be appropriate to the job responsibilities and educational or professional background of the HCW. In medium-risk settings, TB training should be conducted annually. Low-risk settings should annually evaluate the need for TB training, and conduct training as needed. Content should focus on basic information about: TB pathogenesis and transmission, Signs and

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| {0 660} | Continued From page 7<br>symptoms of active TB disease, and Your health care setting ' s infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. A TB infection control program should include the following: written TB infection control procedures. Procedures should address: Early recognition: All health care workers should know the signs and symptoms of TB and their role in their facility's TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. Referral: If your setting does not handle TB patients, transfer potentially infections TB patients to a setting that is equipped to evaluate and treat TB patients.<br><br>No further information was provided. | {0 660} | | |
| {0 730} SS=E | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; | {0 730} | | |

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| {0 730} | Continued From page 8<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had documented assessments of residents related to change in status for three of three residents (R1, R2, R8). | {0 730} | | |

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| {0 730} | Continued From page 9<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 diagnoses included type 2 diabetes, mild intellectual disability, heart failure, chronic obstructive pulmonary disease and hypertension (high blood pressure).<br><br>R1's Service Plan, integrated into R1's assessment, was dated November 30, 2022. R1's service plan indicated R1 received services including medication management, blood sugar checks, dressing/grooming reminders, assist with showers/skin care, behavior management, and alcohol/tobacco supervision.<br><br>On January 9, 2023, at 11:02 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar.<br><br>R1's Concern report dated November 14, 2022, indicated R1 called writer into room to feel hard spot on his back. No visible bumps, but was complaining about a "knot" in the back of his neck.<br><br>R1's Observation notes dated November 14, 2022, indicated concern regarding a resident has been filled out. | {0 730} | | |

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| {0 730} | Continued From page 10<br><br>R1's record lacked documented evidence a registered nurse (RN) followed up on the concern or a physical assessment was conducted by an RN.<br><br>On January 10, 2023, at 1:35 p.m. RN-C stated she had "talked to [R1]" and looked at R1's neck. RN-C stated, "There was nothing there". RN-C stated regarding documentation of follow up for the concerns in R1's record,"I don't see it. I know that's what I did."<br><br>R2<br>R2's diagnoses included dementia and repeated falls.<br><br>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.<br><br>On January 10, 2023, at 8:37 a.m. ULP-F was observed to administer medications to R2.<br><br>R2's record identified the following:<br>-November 10, 2022, Observation note resident has an unusual smell pertaining to her vaginal area and her urine. Concern regarding resident has been filled out. | {0 730} | | |

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| {0 730} | Continued From page 11<br><br>-November 10, 2022, concern regarding a resident report indicated resident has a unusual smell pertaining to her vaginal area and her urine. Urine appeared clear and light yellow in color.<br>-November 10, 2022, Observation note documented by RN-C, indicate no vaginal odor noted during morning cares. No fever, no UTI symptoms notes. Primary was notified via phone.<br><br>R2's record lacked documented evidence a comprehensive assessment of R2 was completed by an RN for unusual smell pertaining to her vaginal area and her urine.<br><br>On January 11, 2023, at 2:46 p.m. RN-C stated she had "looked at [R2]". RN-C stated she had "urine collected. I did not think was abnormal. [R2] had no concerns the next few days."<br><br>-December 22, 2022, Observation note at 2:45 a.m. while toileting resident, when I was assisting wiping the rectum area I noticed blood, then resident squirted blood from rectum onto bathroom floor and toilet. I called nurse (RN-C). She told me she would be in, in the a.m. to look at it and if bleeding continued severely to call back or if resident experienced any pain.<br>-December 22, 2022, Observation note concern regarding resident has been filled out.<br>-December 22, 2022, Concern Regarding a Resident update to concern documented by RN-C, in times when hemorrhoids are problematic use as needed with hazel wipes.<br>-December 22, 2022, Observation note at 9:30 a.m. documented by RN-C, in times when hemorrhoids are problematic use as needed with hazel wipes.<br><br>R2's record lacked documented evidence a physical assessment of R2 was completed by | {0 730} | | |

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| {0 730} | Continued From page 12<br>RN-C for bleeding from rectum.<br><br>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".<br><br>R8<br>R8's diagnoses included dementia.<br><br>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.<br><br>R8's record identified the following:<br>-November 17, 2022, Observation note, concern regarding resident has been filled out.<br>-November 17, 2022, Concern regarding resident lower back pain indicated when staff went into resident room to give 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 10.<br>-November 18, 2022, Observation note documented by RN-C, indicated last night resident had complaints of back pain. Resident did not have any further complaints after getting as needed Tylenol (used to treat pain).<br><br>R8's record lacked documented evidence of | {0 730} | | |

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| {0 730} | Continued From page 13<br>physical assessment by an RN for follow up of back pain.<br><br>On January 11, 2023, at 2:46 p.m. RN-C stated regarding assessment of R8 for follow up of back pain, "yeah, I felt abdomen and back. I don't remember about bowel check. [R8] did not provide any symptoms at that time. They gave PRN (as needed) Tylenol. I suppose I could have had more detail."<br><br>-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) on.<br>-November 20, 2022, Concern Regarding a Resident concern form indicated the same.<br>-November 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.<br><br>R8's record lacked documented evidence of physical assessment by an RN for follow up of butt crack was very red and raw.<br><br>On January 11, 2023, at 2:46 p.m. RN-C stated R8 had scheduled Nystatin for skin concerns. RN-C stated, "When I checked on her that a.m., looked pretty clear at that time." RN-C stated R8 has "bowel incontinence", which "irritates skin." RN-C stated, "I just need better documentation."<br><br>The licensee's MN Initial and Ongoing Assessment of Residents policy dated December 2022, indicated nursing assessments were completed by a registered nurse based upon the required assessment schedule and as needed | {0 730} | | |

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| {0 730} | Continued From page 14<br>based upon resident condition. A RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: 4. Change in resident condition. An RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules.<br><br>No further information was provided. | {0 730} | | |
| {0 800} SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>No further action required. | {0 800} | | |
| 0 900 SS=C | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br><br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management | 0 900 | | |

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| 0 900 | Continued From page 15<br>agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br><br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(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.<br><br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract which was revised for three of three residents (R1, R2, R8).<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected | 0 900 | | |

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| 0 900 | Continued From page 16<br>or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1's admit date was May 3, 2021.<br><br>R2's admit date was July 27, 2021.<br><br>R8's admit date was August 4, 2022.<br><br>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.<br><br>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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |
| {0 930} SS=C | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the facility's complaint resolution process available to | {0 930} | | |

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| {0 930} | Continued From page 17<br>residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br>(e) The contract must include a clear and conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;<br>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;<br>(4) the resident's right to obtain services from an unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced by:<br>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).<br><br>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).<br><br>The findings include:<br><br>On January 9, 2023, at 10:07 a.m. during | {0 930} | | |

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| {0 930} | Continued From page 18 | {0 930} | | |

entrance conference, licensed assisted living director (LALD)-B stated regarding the licensee's contract having required information of the name and contact information of the person representing the facility who is designated to handle and resolve complaints, "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 provided to residents, following survey exited on September 12, 2022. At that time, the evaluator requested a copy of the licensee's revised contract.

The licensee's contract dated December 15, 2022, provided by LALD-B indicated on page 2. "Designated person on-site to handle and resolve complaints: see appendix 5 as the same may be amended form time to time. Any amendments will be communicated to you in writing. On page 12. "C. Complaint Resolution. The executive Director of the community is responsible for ensuring that any complaints are addressed in a satisfactorily and timely manner and will maintain an open door policy for all residents and family members (if a resident chooses family members' participation) to express any concern. Other opportunities to voice concerns include family meetings upon request, and resident council meetings. Step 1. The resident and/or the resident's family member, representative or legal representative may present verbally or in writing to the executive director, complaint or request for change. Appendix 5 to Residents and Services Agreement dated December 27, 2022, indicated "specific contact information for person on site to handle and resolve complaints"; however, no person was listed.

The contract did not address in Appendix 5 the

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| {0 930} | Continued From page 19<br>name and contact information of the designated person on-site to handle and resolve complaints as indicated on page 2. of the contract and did not include the name and contact information of the executive director as indicated on page 12. of the contract.<br><br>R1's admit date was May 3, 2021.<br><br>R2's admit date was July 27, 2021.<br><br>R8's admit date was August 4, 2022.<br><br>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.<br><br>On January 10, 2022, at 10:10 a.m. LALD-B reviewed the licensee's contract and verified the contract did not include the name and contact information of executive director as indicated on page 12. of the contract.<br><br>No further information was provided. | {0 930} | | |
| {01620} SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision | {01620} | | |

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| {01620} | Continued From page 20<br><br>9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed a comprehensive reassessment for change in condition for two of three residents (R2, R8) related to falls, ER visit and change in status and failed to ensure the RN completed accurate assessment for one of three residents (R8).<br><br>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).<br><br>The findings include: | {01620} | | |

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| {01620} | Continued From page 21 | {01620} | | |

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.

On January 10, 2023, at 8:37 a.m. ULP-F was observed to administer medications to R2.

R2's record identified the following:
-December 22, 2022, Resident event report has been filled out.
-December 22, 2022, Post Fall Investigation Form indicated for "Does resident have medical conditions that may contribute to falls" with response of "Yes" and further indicated "answers in this column must be addressed" with direction of "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo".
-December 27, 2022, Resident event Report update to fall documented by RN-C, indicated resident fell on December 22, 2022. Resident was sitting on front couch and fell. Resident was laying on her back in front of the couch. No injuries. Checked for injury. No complaints of pain

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| {01620} | Continued From page 22 | {01620} | | |

related to fall. Staff education done to frequently check on resident when she is in the living room on the couch, Resident enjoys that area. However, she cannot always communicate when she is ready to get back in her wheelchair.

R2's record lacked documented evidence of assessment as indicated on R2's Post fall Investigation Form for "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo" by a RN.

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".

-December 29, 2022, Observation notes resident event report has been filled out.
-December 29, 2022, Post Fall Investigation Form indicated for "Does resident have medical conditions that may contribute to falls" with response of "Yes" and further indicated "answers in this column must be addressed" with direction of "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo". "Complaining of painful urination" was documented in the area.
-January 4, 2023, Resident Event Report update to fall documented by RN-C indicated on December 29, 2022, resident fell, no injuries. resident was sitting in wheelchair and slid down the front of wheelchair on buttocks with legs straight out in front of her. Gripper mat placed in

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| {01620} | Continued From page 23<br>wheelchair.<br><br>R2's record lacked documented evidence of assessment as indicated on R2's Post fall Investigation Form for "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo" by a RN and lacked documented evidence of monitoring and follow up for "complaining of painful urination".<br><br>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". RN-C stated staff were to encourage R2 to drink fluids, but there was no documentation of nursing intervention in R2's record.<br><br>-January 1, 2023, Observation notes concern regarding resident has been filled out.<br>-January 1, 2023, Concern Regarding a Resident Bladder Infection/UTI report indicated resident has cloudy light yellow urine, complaint of stinging and burning when urinating and while wiping the vaginal area.<br>-January 5, 2023, observation note documented by RN-C indicated resident has a UTI. Antibiotic ordered to be given twice daily for 12 days.<br><br>R2's record lacked documented evidence of comprehensive assessment by the RN for change in condition related to UTI.<br><br>On January 10, 2023, at 10:10 a.m. RN-C stated she did not complete a comprehensive | {01620} | | |

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| {01620} | Continued From page 24 | {01620} | | |

assessment of R2 for change in status related to UTI. RN-C stated staff were to encourage R2 to drink fluids, but there was no documentation of nursing intervention in R2's record.

-January 6, 2023, Resident Event Report update to fall documented by RN-C, indicated resident fall on January 3, 2022. Resident wheelchair was in the front living room and resident was not in it. Staff person went looking for her and found resident in her room laying on right side and complained of right hip pain when the staff person completed range of motion with R2. The staff person checked R2's vital signs, assisted R2 off the floor, and took R2 to the dining room for dinner. Instructions given by director on call were to notify R2's guardian and see what wants to do with R2. The staff person called the guardian and the guardian said to keep an eye on R2, see if she complains of any pain throughout the night, if it gets too bad, then send R2 in to get looked at.
-January 5, 2023, Post Fall Investigation Form indicated for "Does resident have medical conditions that may contribute to falls" with response of "Yes" and further indicated "answers in this column must be addressed" with direction of "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo".

R2's record lacked documented evidence of assessment as indicated on R2's Post fall Investigation Form for "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo" by an RN and lacked documented evidence of comprehensive assessment by the RN for change in condition related to the fall (complaints

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| {01620} | Continued From page 25<br>of hip pain) and implementation of an intervention.<br><br>On January 10, 2023, at 10:10 a.m. RN-C stated she did not complete a comprehensive assessment of R2 for change in status related to the fall and "I did not do anything" regarding implementation of an intervention.<br><br>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".<br><br>R8<br>R8's diagnoses included dementia.<br><br>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.<br><br>R8's record identified the following:<br>-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 hospital.<br>-After Visit Summary dated November 23, 2022, (from hospital) indicated "we didn't find any injuries from your fall today. You should take | {01620} | | |

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course of antibiotics for 5 days for a possible bladder infection." Start cefdinir (antibiotic) 300 milligrams (mg) one capsule two times a day before breakfast and dinner for 5 days.
-November 23, 2022, Observation note documented by RN-C, indicated resident seen in emergency room this morning post fall. No injuries found from fall. Started on antibiotics for UTI. CT scan showed thickening of bladder and a repeat CT scan should be done in a few weeks.
-November 23, 2022, Resident Event Report update to fall documented by RN-C, indicated resident fell at 5:40 a.m. in residents bathroom. Resident found on right side between wall and toilet, complained of severe back pain. Was taken to hospital.
-November 23, 2023, Post Fall Investigation Form indicated for "Does resident have medical conditions that may contribute to falls" with response of "Yes" and further indicated "answers in this column must be addressed" with direction of "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo".

R8's record lacked documented evidence of assessment as indicated on R8's Post fall Investigation Form for "review status of medical condition, assess for presence of orthostatic hypotension, assess conditions affecting balance, assess conditions causing dizziness/vertigo" by an RN and lacked documented evidence of comprehensive assessment by the RN for change in condition related to the fall/ER visit and implementation of an intervention.

ACCURATE ASSESSMENT
R8's Medication Administration Record dated January 2023, identified staff were completing for

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| {01620} | Continued From page 27<br>R8 "blood glucose readings, take blood glucose every a.m. before breakfast."<br><br>R8's Service Plan, integrated into R8's assessment dated November 3, 2022, did not include blood glucose check under wellness monitoring/Treatment.<br><br>On January 10, 2023, at 2:45 p.m. LALD-B and RN-C verified R8 received blood sugar checks and further verified the treatment of blood glucose checks was not included in the assessment.<br><br>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".<br><br>The licensee's Emergency Management Plan 3) Resident Fall or Injuries undated indicated 3) "In Minnesota locations, the RN is to be immediately notified of all falls, and based on information received, the nurse will direct the care that the team member is to provide and any immediate actions to be taken. The RN will follow up and complete a thorough assessment of the resident and document the assessment on the Regional Director Cares Assessment Form as well as in ECP and include any recommendations, specific details of any injuries noted, and any required follow up needed regarding the resident."<br><br>The licensee's MN Initial and Ongoing Assessment of Residents policy dated December 2022, indicated nursing assessments were completed by a registered nurse based upon the | {01620} | | |

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| {01620} | Continued From page 28<br>required assessment schedule and as needed based upon resident condition. A RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: 4. Change in resident condition. An RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules.<br><br>No further information was provided. | {01620} | | |
| {01640} SS=E | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan. | {01640} | | |

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| {01640} | Continued From page 29 | {01640} | | |

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised with changes in services 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
The licensee lacked revision of R1's service plan for the treatment service of as needed (PRN) blood sugar checks.

R1's diagnoses included type two diabetes and mild intellectual disability.

R1's Service Plan integrated into R1's Our House Assessment MN was dated November 30, 2022. R1's service plan indicated R 1 received services including medication management, dressing/grooming reminders, assist with showers/skin care, behavior management, alcohol/ tobacco supervision and staff assist with blood sugar checks four times daily.

On January 9, 2023, at 11:02 a.m. unlicensed personnel (ULP)-E was observed to check R1's

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| {01640} | Continued From page 30<br>blood sugar.<br><br>R1's Medication Administration Record dated January 2023, identified "blood glucose check use to test blood sugar (BS) up to 8 times per day."<br><br>On January 11, 2023, at 2:32 p.m. licensed assisted living director (LALD)-B verified the residents service plan and assessments were integrated. LALD-B verified R1 was receiving scheduled blood sugar checks four times ad day and could have blood sugar checked up to eight times a day. LALD-B reviewed R1's Service Plan integrated into R1's Our House Assessment MN November 30, 2022, and stated "yeah, it's not in there" referring to R1's BS checks as needed (PRN) up to eight times a day.<br><br>R8<br>The licensee lacked revision of R8's service plan for the treatment service of blood sugar checks daily.<br><br>R8's diagnoses included dementia.<br><br>R8's Service Plan integrated into R8's Our House Assessment MN 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.<br><br>R8's Medication Administration Record dated January 2023, identified staff were completing for R8 "blood glucose readings, take blood glucose | {01640} | | |

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| {01640} | Continued From page 31<br>every a.m. before breakfast."<br><br>R8's Service Plan integrated into R8's Our House Assessment MN was dated November 3, 2022, did not include blood glucose check under wellness monitoring/Treatment.<br><br>On January 10, 2023, at 2:45 p.m. LALD-B and RN-C verified R8 was receiving the treatment service of blood sugar checks. LALD-A reviewed R8's Service Plan integrated into R8's Our House Assessment MN dated November 3, 2022, and stated the treatment of blood glucose checks was not included.<br><br>The licensee's MN Service Plan Content Policy dated revised June 2020, indicated all residents/tenants have an up-to-date service plan identifying services to be provided based on the assessment by the RN.<br><br>No further information was provided. | {01640} | | |
| {01650} SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service | {01650} | | |

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| {01650} | Continued From page 32 | {01650} | | |

cannot be provided;
(ii) information and a method to contact the facility;
(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record 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:

R1
R1's diagnoses included type two diabetes and mild intellectual disability.

R1's Service Plan, integrated into R1's assessment was dated November 30, 2022. R1's

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| {01650} | Continued From page 33<br>service plan indicated R1 received services including medication management, dressing/grooming reminders, assist with showers/skin care, behavior management, alcohol/ tobacco supervision and staff assist with blood sugar checks four times daily. R1's service plan lacked the treatment service of blood sugar checks up to 8 times per day.<br><br>On January 9, 2023, at 11:02 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar.<br><br>R1's Medication Administration Record dated January 2023, identified "blood glucose check use to test blood sugar (BS) up to 8 times per day."<br><br>R1's Service Plan lacked the following:<br>-description of services to be provided (as needed blood sugar checks), the fees for the service; and<br>-a contingency plan that includes: the action to be taken if the scheduled service cannot be provided.<br><br>R8<br>R8's diagnoses included dementia.<br><br>R8's Service Plan, integrated into R8's assessment, was dated November 3, 2022. R8's service plan included reminders 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 service plan lacked the treatment service of blood glucose check daily. | {01650} | | |

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| {01650} | Continued From page 34<br><br>R8's Medication Administration Record dated January 2023, identified staff were completing for R8 "blood glucose readings, take blood glucose every a.m. before breakfast."<br><br>R8's Service Plan lacked the following:<br>-description of services to be provided (blood sugar checks daily), the fees for the service; and<br>-the identification of staff or categories of staff who will provide the service;<br>-a contingency plan that includes: the action to be taken if the scheduled service cannot be provided.<br><br>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.<br><br>On January 11, 2023, at 2:32 p.m. LALD-B verified the residents' service plan and assessments were integrated. LALD-B verified R1 was receiving scheduled blood sugar checks four times a day and could have blood sugar checked up to eight times a day. LALD-B reviewed R1's Service Plan and stated "yeah, it's not in there."<br><br>On January 10, 2023, at 2:45 p.m. LALD-B and RN-C verified R8 was receiving the treatment service of blood sugar checks. LALD-A reviewed R8's Service Plan and verified the treatment of blood glucose checks was not included.<br><br>The licensee's MN Service Plan Content Policy dated revised June 2020, indicated all | {01650} | | |

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| {01650} | Continued From page 35<br>residents/tenants have an up-t-date service plan identifying services to be provided based on the assessment by the RN and the service plan would include a description of the home care services, including treatments, the frequency of the services, the fees for the service, identification of the team members or categories of team members who would provide the service and a contingency plan that included the action plan to be taken by our agency, the resident/tenant, and/or responsible party if the scheduled service cannot be provided.<br><br>No further information was provided. | {01650} | | |
| 01700 SS=D | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and | 01700 | | |

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| 01700 | Continued From page 36 | 01700 | | |

provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure assessment of medication management services included all required content for one of three residents (R8).

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

The findings include:

R8 had an admission date of August 4, 2022, with diagnoses including dementia.

R8's Service Plan, integrated into R8's assessment dated November 3, 2022, included the service of medication management. The assessment indicated for "Medications" company to administer all medications, staff assist with medications three times per day or less (includes PRN [as needed]) (doctor orders). List all medications including prescriptions, over the counter medications and supplements. Include

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| 01700 | Continued From page 37 | 01700 | | |

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 order. Primary MD is notified by pharmacy and facility is also notified as appropriate. All medications are stored, refrigerated if indicated and administered per manufacturer guideline/recommendations. List any medication allergies: anesthesia, codeine, penicillin's, bacitracin. Medication assessment of the potential for medication diversion and interventions to prevent diversion. All medications are locked with one staff member assigned to medication administration at a time. Med room/med cart keys are exchanged from the med passer to med passed hands and all narcotics are double locked and counted at the end and beginning of every shift.

The assessment did not specifically reference a med list for "See Med list See Med list name, dosage, route, frequency, diagnosis, side effects, and adverse reactions" on the assessment and R8's record lacked documented evidence of 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

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| 01700 | Continued From page 38<br>indicated on the assessment.<br><br>R8's MAR dated January 2023, indicated staff were administering one medication used as preventive for heart, one for high cholesterol, one for diabetes, one supplement, one used to treat hypothyroidism, one for constipation, one for high blood pressure, one for skin infections and one used for pain.<br><br>R8's record lacked a medication assessment by the RN for the following required content:<br>-documentation the assessment was conducted face-to-face with the resident; and<br>-identification of indications and side effects<br>-review of side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and<br>-provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>On January 9, 2023, at 10:07 a.m. during the entrance conference, licensed assisted living director (LALD)-B stated "we are still developing that as of Friday. Paper version to use. We haven't done anyone yet." RN-C stated, "I was going to start this week."<br><br>On January 10, 2023, at 12:31 p.m. LALD-B stated the med list referenced on the assessments was the resident's MAR. LALD-B stated the pharmacist completed the reviews for contraindications for medications. LALD-B stated the review by the pharmacist was not part of the resident record. LALD-B stated she could call the pharmacist and ask for the information.<br><br>On January 10, 2023, at 2:21 p.m. LALD-B stated | 01700 | | |

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| 01700 | Continued From page 39<br>the pharmacist was out and would be back tomorrow to provide the information for review of contraindications for medications for R8.<br><br>The licensee's MN Initial and Ongoing Assessment of Residents policy dated December 2022, indicated nursing assessments were completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. An RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01700 | | |
| {01710} SS=E | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure reassessment of medication management services at a minimum annually for two of three residents (R1, R2). | {01710} | | |

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| {01710} | Continued From page 40 | {01710} | | |

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

The findings include:

R1
R1 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) (COPD), and depression.

R1's Service Plan, integrated into R1's assessment dated November 30, 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 [as needed]) (doctor 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 order. Primary MD is notified by pharmacy and facility is also notified as appropriate. All

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| {01710} | Continued From page 41 | {01710} | | |

medications are stored, refrigerated if indicated and administered per manufacturer guideline/recommendations. List any medication allergies: (nothing was documented in this area). Medication assessment of the potential for medication diversion and interventions to prevent diversion. All medications are locked with one staff member assigned to medication administration at a time. Med room/med cart keys are exchanged from the med passer to med passed hands and all narcotics are double locked and counted at the end and beginning of every shift.

The assessment did not specifically reference a med list for "See Med list See Med list name, dosage, route, frequency, diagnosis, side effects, and adverse reactions" on the assessment and R1's record lacked documented evidence of review for "Contraindication is verified by pharmacy on admission and with every new order as indicated on the assessment.

R1's Medication Administration Records (MARs) dated November 2022, December 2022, and January 2023, identified the name, dosage, route, frequency and indications for medications being administered by staff to R1. The MARs indicated Allergies: no known allergies. The MARs lacked side effects of all medications listed and adverse reactions as indicated on the assessment.

R1's MAR dated January 2023, indicated staff were administering two medications for syncope episode (fainting or passing out), two for congestive heart failure, two for sleep, six for diabetes, three for COPD, one for depression, two for nasal lubricant. one for agitation, two for pain, one for chest pain, one for acid reflux and one for thick toenails.

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| {01710} | Continued From page 42<br><br>R1's record lacked a medication reassessment by the RN for the following required content:<br>-documentation the assessment was conducted face-to-face with the resident; and<br>-identification of side effects<br>-review of side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and<br>-provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>R2<br>R2 had an admission date of July 27, 2021, with diagnoses including dementia and repeated falls.<br><br>On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R2.<br><br>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 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 | {01710} | | |

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order. Primary MD is notified by pharmacy and facility is also notified as appropriate. All medications are stored, refrigerated if indicated and administered per manufacturer guideline/recommendations. List any medication allergies: NSAIDs (nonsteroidal anti-inflammatory drug). Medication assessment of the potential for medication diversion and interventions to prevent diversion. All medications are locked with one staff member assigned to medication administration at a time. Med room/med cart keys are exchanged from the med passer to med passed hands and all narcotics are double locked and counted at the end and beginning of every shift.

The assessment did not specifically reference a med list for "See Med list See Med list name, dosage, route, frequency, diagnosis, side effects, and adverse reactions" on the assessment and R2's record lacked documented evidence of review for "Contraindication is verified by pharmacy on admission and with every new order as indicated on the assessment.

R2's MAR's dated November 2022, December 2022, and January 2023, identified the name, dosage, route, frequency and indications for medications being administered by staff to R2. The MARs indicated Allergies: NSAIDs. The MARs lacked side effects of all medications listed and adverse reactions as indicated on the assessment.

R2's MAR dated January 2023, indicated staff were administering one medication used to treat gout, four supplements, one used to treat hypothyroidism, one used for sleep, four used for constipation, one used for depression, one used for sleep, one used for pain, one used to

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strengthen bones, three used for dry eyes, one used for restlessness, one used for sore throat and one used to treat infection.

R2'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.

On January 9, 2023, at 10:07 a.m. during the entrance conference, licensed assisted living director (LALD)-B stated regarding medication assessment, "we are still developing that as of Friday. Paper version to use. We haven't done anyone yet." RN-C stated, "I was going to start this week."

On January 10, 2023, at 12:31 p.m. LALD-B stated the med list referenced on the assessments was the resident's MAR. LALD-B stated the pharmacist completed the reviews for contraindications for medications. LALD-B stated the review by the pharmacist was not part of the resident record. LALD-B stated she could call the pharmacist and ask for the information.

On January 10, 2023, at 2:21 p.m. LALD-B stated the pharmacist was out and would be back tomorrow to provide the information for review of contraindications for medications for R1 and R2.

The licensee's MN Initial and Ongoing

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| {01710} | Continued From page 45<br><br>Assessment of Residents policy dated December 2022, indicated nursing assessments were completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. An RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules.<br><br>No further information was provided. | {01710} | | |
| {01730} SS=E | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel; | {01730} | | |

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| {01730} | Continued From page 46<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan to include all required content for three of three residents (R1, R2, R8).<br><br>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).<br><br>The findings include:<br><br>R1 | {01730} | | |

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| {01730} | Continued From page 47<br><br>R1's Service Plan, integrated into R1's assessment dated November 30, 2022, indicated R1 received medication management.<br><br>R1's Medication Administration Record (MAR) dated January 2023, indicated staff were administering two medications for syncope episode (fainting or passing out), two for congestive heart failure, two for sleep, six for diabetes, three for chronic obstructive pulmonary disorder (COPD), one for depression, two for nasal lubricant. one for agitation, two for pain, one for chest pain, one for acid reflux and one for thick toenails.<br><br>R1's individualized medication management record lacked the following:<br>-documentation of specific resident instructions relating to the administration of medications;<br>-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>-identification of medication management tasks that may be delegated to unlicensed personnel;<br>-procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>-any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R2<br>R2's Service Plan, integrated into R2's assessment dated November 16, 2022, indicated R2 received medication management. | {01730} | | |

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| {01730} | Continued From page 48<br><br>On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to administer medications to R2.<br><br>R2's MAR dated January 2023, indicated staff were administering one medication for gout, four supplements, one for hypothyroidism, one for sleep, four for constipation, one for depression, one for pain, one to strengthen bones, three for dry eyes, one for restlessness, one for sore throat and one to treat infection.<br><br>R2's individualized medication management record lacked the following:<br>-documentation of specific resident instructions relating to the administration of medications;<br>-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>-identification of medication management tasks that may be delegated to unlicensed personnel;<br>-procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>-any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R8<br>R8's Service Plan integrated into R8's assessment dated November 3, 2022, indicated R2 received medication management.<br><br>R8's MAR dated January 2023, indicated staff were administering one medication used as preventive for heart, one for high cholesterol, one | {01730} | | |

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| {01730} | Continued From page 49 | {01730} | | |

for diabetes, one supplement, one for hypothyroidism, one for constipation, one for high blood pressure, one for skin infections and one for pain.

R8's individualized medication management record lacked the following:
-documentation of specific resident instructions relating to the administration of medications;
-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
-identification of medication management tasks that may be delegated to unlicensed personnel;
-procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
-any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

On January 9, 2023, at 10:07 a.m. during the entrance conference, licensed assisted living director (LALD)-B stated the licensee had developed a "new" individualized medication management record. Paper version to use. We haven't done anyone yet." RN-C stated, "I was going to start this week."

The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated revised June 2020, indicated the RN would develop and individualized medication management plan for each resident/tenant receiving any type of medication management services.

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| {01730} | Continued From page 50<br><br>No further information was provided. | {01730} | | |
| {01760} SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medication was administered as prescribed for one of one resident (R2) who was observed for medication administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). | {01760} | | |

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| {01760} | Continued From page 51<br>The findings include:<br><br>R2's prescriber orders dated August 15, 2022, included fiber dissolve one-half teaspoonful in eight ounces of water and take by mouth daily.<br><br>On January 10, 2023, at 8:37 a.m. unlicensed personnel (ULP)-F was observed to obtain fiber powder medication. ULP-F stated one half teaspoon was to be given to R2. ULP-F used a white plastic spoon to scoop the fiber medication out of the container and placed the medication into a white paper medication cup. The evaluator stopped ULP-F and asked what was used to measure the medication and ULP-F stated, "I used a plastic spoon. I don't have a way to measure." The evaluator asked ULP-F if the clear plastic medication cups had measurements on. ULP-F picked up the clear medication cup and stated, "Yes". ULP-F placed the fiber medication cup from the white paper medication cup into the clear medication cup with measurements. The evaluator asked ULP-F how much medication was in the cup and ULP-F responded "one teaspoon". ULP-F removed some of the medication until one half teaspoon was remaining in the medication cup. ULP-F mixed the medication into the water and gave the medication to R2 to drink.<br><br>On January 10, 2023, at 12:00 p.m. licensed assisted living director (LALD)-B stated, "[ULP-F] talked to me. I put on the MAR [medication administration record] to use the measuring cup."<br><br>No further information was provided. | {01760} | | |
| {01940} SS=E | 144G.72 Subd. 3 Individualized treatment or therapy managemen | {01940} | | |

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| {01940} | Continued From page 52<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individualized treatment or therapy management record to include all required content for two of three residents (R1, R8). | {01940} | | |

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| {01940} | Continued From page 53<br><br>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).<br><br>The findings include:<br><br>On January 9, 2023, at 10:07 a.m. during the entrance conference, licensed assisted living director (LALD)-B stated the licensee's treatment plans for residents was "in progress."<br><br>R1<br>R1's Service Plan, integrated into R1's assessment dated November 30, 2022, indicated R1 received treatment management. The assessment included "wellness monitoring/treatment" resident has diagnoses of mild intellectual disability and diabetes type 2. Resident is non compliant with diabetes. Staff are to encourage him to choose the sugar free options or eat less sugar. Is on scheduled insulin and blood glucose checks four times daily. "RCA" (resident care assistant) to complete blood sugar checks four times a day. Blood sugar range 70-300. Resident does have an order for glucose tablets. Order reads: chew and swallow 3 to 4 tabs for blood sugar less than 60, then recheck blood sugar after 15 minutes. If blood sugar is still below 60, all EMS (emergency medical services). R1's service plan/assessment lacked the treatment service of as needed (PRN) blood sugar checks. | {01940} | | |

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| {01940} | Continued From page 54<br><br>On January 9, 2023, at 11:02 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar.<br><br>R1's Medication Administration Record dated January 2023, identified blood glucose check used to test blood sugar (BS) up to 8 times per day. When blood sugar is 70 or less give one glucose tab immediately then call notify the nurse for further instruction. The MAR identified staff were recording blood sugar checks for the scheduled times of 7:00 a.m., 11:00 a.m., 5:00 p.m. and 8:00 p.m. every day.<br><br>R1's service pan lacked a written statement of the treatment or therapy services that would be provided to the resident (PRN blood sugar checks) and lacked a current individualized treatment and therapy management record for the treatment service of PRN blood sugar checks for the following:<br>-identification of treatment or therapy tasks that will be delegated to unlicensed personnel.<br><br>On January 11, 2023, at 2:32 p.m. LALD-B verified R1 was receiving scheduled blood sugar checks four times a day and could have blood sugar checked up to eight times a day. LALD-B verified R1's record lacked the above for treatment management record.<br><br>R8<br>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 | {01940} | | |

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management, meals, housekeeping and orientation. R8's service plan/assessment lacked the treatment service of blood sugar checks every day.

R8's Medication Administration Record dated January 2023, read "blood glucose readings, take blood glucose every a.m. before breakfast."

R8's service plan lacked a written statement of the treatment or therapy services that would be provided to the resident (blood sugar checks every a.m.) and lacked a current individualized treatment and therapy management record for the treatment service of blood sugar checks every a.m. for the following:
-documentation of specific resident instructions relating to the treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
-any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

On January 10, 2023, at 2:45 p.m. LALD-B and RN-C verified R8 was receiving the treatment service of blood sugar checks. LALD-A verified

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| {01940} | Continued From page 56<br>the treatment of blood glucose checks was not included in the service plan.<br><br>The licensee's MN Service Plan Content Policy dated revised June 2020, indicated all residents/tenants have an up-to-date service plan identifying services to be provided based on the assessment by the RN.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated revised June 2020, indicated the RN would develop and individualized treatment plan for each resident/tenant and would develop specific procedures for treatments that team members would provide.<br><br>No further information was provided. | {01940} | | |
| {01970} SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure a prescriber's order for treatment or therapy for one of three residents (R1). | {01970} | | |

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| | 30630 | A. BUILDING: _____ B. WING _____ | R 01/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KSMS OUR HOUSE LLC | 204 14TH ST NW AUSTIN, MN 55912 |

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| {01970} | Continued From page 57 | {01970} | | |

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

The findings include:

R1's diagnoses included type two diabetes and mild intellectual disability.

R1's Service Plan, integrated into R1's assessment dated November 30, 2022, indicated R1 received treatment services which included blood sugar checks four times daily.

On January 9, 2023, at 11:02 a.m. unlicensed personnel (ULP)-E was observed to check R1's blood sugar.

R1's Medication Administration Record (MAR) dated January 2023, identified "blood glucose check use to test blood sugar (BS) up to 8 times per day."

R1's record included a prescriber's order dated August 24, 2022, for accu-check guide test strip use to test BS up to 8 times daily.

R1's record lacked a prescriber's order for scheduled BS checks four times daily.

On January 11, 2023, at 2:32 p.m. licensed assisted living director (LALD)-B there was "no signed order" in R1's record scheduled BS checks four time daily. RN-B stated she "could

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| {01970} | Continued From page 58<br>contact [nurse practioner] to make more specific."<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the company required a prescription for all medication and treatment services team members manage for the residents. The RN was responsible for ensuring current prescriptions from authorized prescriber for treatments and therapies to be administered by the team members and the orders were kept in the resident record.<br><br>No further information was provided. | {01970} | | |
| {02110} SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care; | {02110} | | |

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| {02110} | Continued From page 59<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2022. | {02110} | | |

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| {02110} | Continued From page 60<br><br>The licensee lacked the following policies and procedures related to dementia care:<br>- philosophy of how services are to be provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy will be implemented;<br>- medication management, including an assessment of residents for the use and effects of medications- lacks content that includes psychotropic medications;<br>- description of life enrichment programs and how activities are implemented;<br>- description of family support programs and efforts to keep family engaged;<br>- limiting the use of public address and intercom systems for emergencies and evacuation drills;<br>- transportation coordination and assistance to and from outside medical appointments; and<br>- safekeeping of residents' possessions<br><br>In addition, the licensee's Behavior Monitoring Record Policy and Procedure revised May 2020, lacked content which addressed design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed.<br><br>The licensee failed to provide policies and procedures to residents and the residents' legal and designated representative at the time of move in.<br><br>On January 9, 2023, at 10:07 a.m. licensed assisted living director (LALD)-B stated during the entrance conference dementia policies were developed. LALD-B stated dementia policies were not provided to the residents and the residents' legal and designated representatives, but were "going to be sent out with new contract | {02110} | | |

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| {02110} | Continued From page 61<br>on the 19th of January." LALD-B then stated, "By Friday the 13th should be ready to go." Policies for dementia were requested by the evaluator.<br><br>On January 11, 2023, at 2:12 p.m. LALD-B reviewed the licensee's Behavior Monitoring Record Policy and Procedure revised May 2020, and stated she did not see in the policy content which addressed design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed was addressed. LALD-B stated she had more dementia policies and would provide them, regarding the above listed policies. LALD-B stated a policy for philosophy of how services are to be provided was "still being developed by the home office."<br><br>On January 11, 2023, at 3:36 p.m. LALD-B stated policies she already provided for the licensee's dementia policies was all she had.<br><br>No further information was provided. | {02110} | | |
| {03000} SS=E | 626.557 Subd. 3 Timing of report<br><br>(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:<br>(1) the individual was admitted to the facility from | {03000} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {03000} | Continued From page 62 | {03000} | | |

another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {03000} | Continued From page 63<br>Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse for two of two residents (R9, R1).<br><br>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).<br><br>The findings include:<br><br>The licensee lacked immediate report to MAARC of staff to resident physical and verbal abuse.<br><br>R9<br>R9's diagnoses included dementia.<br><br>R9's MAARC report identified estimated date of incidence was November 8, 2022. A description of the incident indicated an unlicensed personnel (ULP) reported she saw ULP-J forcing R9 back into her wheelchair by her shoulders and told R9 to "shut up". R9 was not able to confirm or deny. ULP also stated she heard ULP-J telling R9 to shut up during one of her behaviors. There were no other witnesses. "This staff member [ULP-J] was suspended that day and no longer works here."<br><br>The MAARC Form identified Date/Time Submitted was Tuesday November 15, 2022, at 3:59 p.m. (seven days after date of incidence occurred on November 8, 2022). | {03000} | | |

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| {03000} | Continued From page 64<br><br>R1<br>R1's diagnoses included dementia.<br><br>R1's MAARC report identified the estimated date of incidence was November 8, 2022. A description of the incident indicated R1 was wanting more coffee and ULP-J ignored him for a minute and then told him to "shut up" and she would get some in a minute. This was the statement provided by a staff person. "This nurse is seeing this report for the first time today. Assistant director had taken [ULP-J] off of the schedule while she completed the investigation. [ULP-J] no longer works here. November 8, 2022, was the last time she was in the facility."<br><br>The MAARC Form identified Date/Time Submitted was Tuesday November 15, 2022, at 4:16 p.m. (seven days after date of incidence occurred on November 8, 2022).<br><br>Investigation Summary event date November 9, 2022, indicated date and time November 9, 2022, at 8:15 a.m. assistant director reported to work and found multiple notes on her desk. The first note read "11/8/22 [ULP-J] is really mean to residents. She yells at [R1] and [R9] and tells them to shut up. When the residents ask for more food she either ignores them or tells them they cannot have anymore." "This note was written by resident care assistant (RCA) [ULP-K]." "The second note reads: [ULP-J] is very rude to the residents. I heard her tell [R1] to shut up when he asked for more coffee. She also told [R9] to shut up during one of her behaviors. When [R9] was standing up I saw [ULP-J] grab [R9] by the shoulders and force her down into her wheelchair. This was also dated 11/8/22 written by RCA [ULP-L]." The Investigation Summary | {03000} | | |

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| {03000} | Continued From page 65<br>further indicated on November 15, 2022, "VA [vulnerable adult] report was completed."<br><br>On January 9, 2022, at 2:01 p.m. registered nurse (RN)-C stated, "We became aware" of the incidences above "on November 9". "Staff left random notes. We had to do an investigation. I was off a few days between. I realized they should of been filed days ago. I waited until investigation notes came back to us." RN-C stated the former licensed assisted living director (LALD-A) said to wait with reporting (filing a MAARC report). RN-C stated we educated staff and informed staff "call, no notes."<br><br>The licensee's Reporting Resident/Tenant Abuse, Neglect, Stealing, Etc. Policy revised April 2022, indicated team members who suspect or have witnessed questionable activities (physical) or communication (verbal or written) of another resident/tenant, caregiver or other team member, visitor, or non-caregiver are required to report the suspicions to the director or other management staff immediately and confidentially, regardless of if they have all the facts or are unsure of their feelings or assumptions. The policy further indicated the state of Minnesota requires reporting immediately, regardless of the facts, by the director or assistant director to the MAARC any unexplained injuries, which are defines as if a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained.<br><br>No further information was provided. | {03000} | | |

DEPARTMENT OF HEALTH

*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

§ 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

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. Please note that you 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**

**Minnesota Department of Health**
**Health Regulation Division**

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30630 | A. BUILDING: _____ B. WING _____ | 09/12/2022 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL30630015<br><br>On September 6, 2022, through September 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 17 residents; all of whom were receiving services under the provider's Assisted Living with Dementia Care license.<br><br>On September 8, 2022, the immediacy of correction orders 2310 has been removed; however, non-compliance remains at a level 3, isolated (G).<br><br>On September 9, 2022, the immediacy of correction orders 1750 has been removed; however, non-compliance remains at a level 3, widespread (I). | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3. | |

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| 0 110 | Continued From page 1 | 0 110 | | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>On September 6, 2022, at approximately 10:00 a.m. LALD-A's license for LALD was observed posted in the entrance area of the facility. LALD-A informed she was the LALD for three separate licensed facilities.<br><br>On September 6, 2022, at 12:04 p.m. the Minnesota Board of Executives for Long-Term | 0 110 | | |

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| 0 110 | Continued From page 2<br><br>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.<br><br>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.<br><br>On September 6, 2022, at 2:56 p.m. LALD-A stated she had received an email from the representative of BELTSS regarding what she needed to do.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 250 SS=F | 144G.20 Subdivision 1 Conditions<br><br>(a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:<br>(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;<br>(2) permits, aids, or abets the commission of any | 0 250 | | |

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| 0 250 | Continued From page 3<br>illegal act in the provision of assisted living services;<br>(3) performs any act detrimental to the health, safety, and welfare of a resident;<br>(4) obtains the license by fraud or misrepresentation;<br>(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;<br>(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;<br>(7) interferes with or impedes a representative of the department in contacting the facility's residents;<br>(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;<br>(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;<br>(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;<br>(11) refuses to initiate a background study under section 144.057 or 245A.04;<br>(12) fails to timely pay any fines assessed by the commissioner;<br>(13) violates any local, city, or township ordinance relating to housing or assisted living services;<br>(14) has repeated incidents of personnel performing services beyond their competency level; or<br>(15) has operated beyond the scope of the assisted living facility's license category.<br>(b) A violation by a contractor providing the assisted living services of the facility is a violation | 0 250 | | |

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| 0 250 | Continued From page 4<br>by the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on September 6, 2022, at approximately 10:27 a.m. licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.<br><br>The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: | 0 250 | | |

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| 0 250 | Continued From page 5<br><br>- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.<br><br>- 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.<br><br>- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.<br><br>- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.<br><br>- Reporting of Maltreatment of Vulnerable Adults.<br><br>- Electronic Monitoring in Certain Facilities.<br><br>- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law | 0 250 | | |

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| 0 250 | Continued From page 6<br>enforcement office to enhance investigative or enforcement efforts or further a public health protective<br><br>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.<br><br>- 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.<br><br>- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.<br><br>- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required.<br><br>- I attest to have all required policies and | 0 250 | | |

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| 0 250 | Continued From page 7<br>procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable.<br><br>Page five was electronically signed by LALD-A on May 24, 2022.<br><br>The licensee had an assisted living license issued on August 1, 2022.<br><br>The licensee failed to ensure the following policies and procedures were developed and/or implemented:<br>-requirements in section 626.557, reporting of maltreatment of vulnerable adults;<br>-training, and competency evaluations of staff;<br>-handling complaints regarding staff or services provided by staff;<br>-conducting ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;<br>-orientation to and implementation of the assisted living bill of rights;<br>-infection control practices;<br>-conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;<br>-medication and treatment management;<br>-delegation of tasks by registered nurses or licensed health professionals;<br>-supervision of unlicensed personnel performing delegated tasks. | 0 250 | | |

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| 0 250 | Continued From page 8<br><br>As a result of this survey, the following orders were issued 0510, 0620, 0630, 0660, 1370, 1380, 1420, 1440, 1620, 1710, 1730, 1750, 1760, 1790, 1820, 1880, 1940, 1950, 1960, 1970, 2310, 2480, and 3000, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 250 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable | 0 470 | | |

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| 0 470 | Continued From page 9<br>amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the staffing plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted with all required information. This had the potential to affect all residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee failed to develop and implement a staffing plan for determining its staffing level that:<br>- ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>- ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility | 0 470 | | |

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| 0 470 | Continued From page 10<br><br>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.<br><br>On September 7, 2022, at 12:37 p.m. RN-C stated the licensee had no staffing plan. RN-C stated she found an email regarding "discussion about staffing plan, looking for more hours", but she could not find a plan. RN-C stated, "The nurse [licensed practical nurse (LPN)-G] that did this, is gone."<br><br>On September 8, 2022, at 12:54 p.m. RN-C provided the email regarding the discussion of staffing. The email was dated April 21, 2022, and indicated the discussion was about increasing scheduled staff hours. RN-C stated she was "looking for more" information regarding a staffing plan. At 1:17 p.m., RN-C stated she had "no other information".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 485 SS=C | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and | 0 485 | | |

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| 0 485 | Continued From page 11<br>fresh vegetables. The following apply:<br><br>(A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes;<br><br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines. This had the potential to affect all 17 residents.<br><br>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).<br><br>The findings include:<br><br>The licensee failed to serve what was posted for the lunch meal and failed to ensure the meal served met the recommended MyPlate: A Guide (half plate fruit and vegetables/protein: a palm sized amount at lunch and dinner/Grains: one | 0 485 | | |

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| 0 485 | Continued From page 12<br>quarter of plate/dairy: three serving per day). In addition, the licensee failed to ensure the licensee's weekly menu included the recommended daily dietary allowances according to USDA guidelines.<br><br>On September 6, 2022, at approximately 10:27 a.m. during the entrance conference, surveyor requested information for the licensee's weekly menu.<br><br>LUNCH MEAL SERVED<br>On September 6, 2022, at 11:21 a.m. observation of the dining room chalk board on the wall indicated for "lunch" the food to be served was "salad, spaghetti, garlic bread, ice cream". At 12:30 p.m., unlicensed personnel (ULP)-D was observed to serve the lunch meal to the residents. The food ULP-D served was spaghetti with meat sauce, garlic toast and drinks of preference (juice, milk, coffee, water). At the time another unidentified staff person came into the kitchen and placed a can of fruit cocktail, marshmallows and whip cream into a bowl and mixed up the ingredients. ULP-D stated the mixture was "fruit fluff" and was the desert. ULP-D was observed to serve the desert to residents. ULP-D did not serve the residents "salad" and "ice cream" as indicated on the chalk board.<br><br>The licensee's "week 3" menu provided to surveyor indicated for "Tuesday lunch" the following food would be served: "tossed green salad, spaghetti with meat sauce, garlic bread, ice cream du jour [of the day], LF [low fat] milk 4 oz [ounces]". The menu lacked a listed fruit to be served according to USDA guidelines.<br><br>WEEKLY MENU | 0 485 | | |

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| 0 485 | Continued From page 13<br>The "week 3" menu identified the following foods were listed for meals:<br>Sunday<br>Breakfast: juice of choice, assorted hot/cold cereal, eggs, sausage link, blueberry muffin, fresh fruit, LF milk 8 oz.<br>Lunch: dinner rolls, roast turkey, mashed potatoes, brown gravy, broccoli and cauliflower, pumpkin pie, LF milk 4 oz.<br>Dinner: bread, hot ham and cheese sandwich, pea salad, peanut butter bars, LF milk 4 oz.<br><br>Monday<br>Breakfast: juice of choice, assorted hot/cold cereal, strawberry waffle, fresh seasonal fruit, LF milk 8 oz.<br>Lunch: bread, Salisbury steak, baked potatoes, carrot coins, frosted yellow cake, LF milk 4 oz.<br>Dinner: navy bean soup, crackers, garden tuna sandwich, fruit cup, LF milk 4 oz.<br><br>Tuesday<br>Breakfast: juice of choice, assorted hot/cold cereal, scrambled eggs, raisin toast, fruit, LF milk 8 oz.<br>Lunch: tossed green salad, spaghetti with meat sauce, garlic bread, ice cream du jour, LF milk 4 oz.<br>Dinner: bread, chicken pot pie, beets, rainbow gelatin, LF milk 4 oz.<br><br>Wednesday<br>Breakfast: juice of choice, assorted hot/cold cereal, pancakes with syrup, sausage patty, fresh seasonal fruit, LF milk 8 oz.<br>Lunch: dinner rolls, orient pork cutlets, chicken rice, oriental vegetables, spice cake, LF milk 4 oz.<br>Dinner: very vegetable soup, crackers, Grilled turkey and Swiss, peanut butter cookies scratch, LF milk 4 oz. | 0 485 | | |

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| 0 485 | Continued From page 14<br><br>Thursday<br>Breakfast: juice of choice, assorted hot/cold cereal, scrambled eggs, hashbrowns, fresh seasonal fruit, LF milk 8 oz.<br>Lunch: bread meat loaf, brown gravy, mashed potatoes, corn, Dutch apple pie with cr top, LF milk 4 oz.<br>Dinner: cheese soup, crackers, chicken salad on croissant, nila banana pudding, LF milk 4 oz.<br><br>Friday<br>Breakfast: juice of choice, assorted hot/cold cereal, biscuits/sausage gravy, fresh seasonal fruit, LF milk 8 oz.<br>Lunch: bread, baked fish, baked tater tots, applesauce, marble cake, LF milk 4 oz.<br>Dinner: tossed green salad, salad dressing of choice, bread basket, lasagna, fruit Jello with topping, LF milk 4 oz.<br><br>Saturday<br>Breakfast: juice of choice, assorted hot/cold cereal, scrambled eggs, toast, fresh seasonal fruit, LF milk 8 oz.<br>Lunch: dinner rolls, ham/potatoes/broccoli hotdish, mixed vegetables, peach cobbler, LF milk 4 oz.<br>Dinner: club sandwich, carrot raisin salad, chips, molasses cookies, LF milk 4 oz.<br><br>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 stated the menu being utilized was provided from a food service company and the licensee was "working on new ones", but the licensee had not "rolled out yet". LALD-A reviewed the licensee's | 0 485 | | |

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| 0 485 | Continued From page 15<br>week three (3) menu and verified snacks were not indicated on the menu and there were no other beverages listed on the menu besides milk. LALD-A stated snacks were served three times a day, which included an a.m. snack with activity, p.m. snack and HS (bedtime) snack. LALD-A verified the menu did not consistently include the daily recommended dietary allowances to be served for vegetable and fruit according to the USDA guidelines. LALD-A confirmed the menu listed "fruit or "fresh seasonal fruit" on some dates, but did not indicate what the fruit being served was. LALD-A confirmed the menu did not always indicate what protein was being served.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 0 510 | | |

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| 0 510 | Continued From page 16<br>review the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for current recommendations for COVID-19. In addition, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to handwashing during medication and treatment administration for two of two residents (R2, R1). This had the potential to affect all residents, staff and visitors.<br><br>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).<br><br>The findings include:<br><br>POSTED SCREENING COVID-19<br>The licensee failed to post signage of restrictions for COVID-19 at facility entrances.<br><br>On September 6, 2022, at 10:00 a.m. upon entrance to the facility, there was no signage posted at the facility entrances for screening or restrictions for infection prevention and control for COVID-19.<br><br>On September 7, 2022, at 12:46 p.m. registered nurse (RN)-B observed the facility entrance area and confirmed there was no signage posted at the facility entrance for screening or restrictions for infection prevention and control for COVID-19. | 0 510 | | |

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| 0 510 | Continued From page 17<br>RN-B stated, "I'm not sure what happened with that. It used to be up".<br><br>The CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated February 2, 2022, indicated ensure everyone is aware of recommended IPC practices in the facility. Post visual alert icons (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations.<br><br>HAND HYGIENE<br>R2<br>The licensee failed to ensure handwashing before and after medication administration.<br><br>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 | 0 510 | | |

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| 0 510 | Continued From page 18 | 0 510 | | |

medication and failed to wash hands prior to leaving R2's room.

On September 8, 2022, at 2:27 p.m. RN-B stated she would expect gloves to be removed and hands cleansed with hand sanitizer or washed in the bathroom before administration of medications and prior to leaving R2's room.
R1
The licensee failed to ensure handwashing following treatment of blood sugar testing.

On September 7, 2022, 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 gloves and prepared equipment. ULP-E wiped the end of R1's middle finger with an alcohol wipe, allowed to dry and then used lancet to poke outside of middle finger creating a drop of blood that was placed on the test strip in glucometer. The lancet was placed on the lid of the container that held the testing equipment. ULP-E then provided R1 with a cotton ball to hold at poked area. The glucometer provided a blood glucose reading of 93. ULP-E gathered equipment and container and returned to the medication room, unlocked the medication room door with the same gloves, placed the lancet in the sharps container, removed the gloves and continued to document blood glucose reading in the electronic medication record. ULP-E then closed medication

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| 0 510 | Continued From page 19<br>closet door and locked it.<br><br>ULP-E touched multiple surfaces with her gloved hands following glucose testing and failed to wash hands following glove removal.<br><br>On September 12, 2022, at approximately 12:00 p.m. RN-B stated that they just had a discussion about using good infection control and that staff are expected to remove gloves and wash hands.<br><br>The licensee's Novel Coronavirus-19 Procedure policy dated June 2020, indicated the executive director was responsible for communication with residents, staff, families and regular visitors regarding the precautions taken by the location to protect residents and staff. The policy further indicated there were posters available that could be posted in your location to provide guidance to families, visitors, residents, and team members.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have | 0 550 | | |

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| 0 550 | Continued From page 20<br>information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure. This had the potential to affect all residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include:<br>-the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances;<br>-the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center<br><br>On September 6, 2022, at 11:30 a.m. observation of information posted for the facility grievance procedure included information of the licensee's grievance procedure and was posted in an | 0 550 | | |

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| 0 550 | Continued From page 21<br>enclosed glass bulletin board case on a wall in a hallway. The posted information was not accessible to persons (to view more than one page of a document posted) and lacked information of the name, telephone number, and e-mail contact information for the individuals responsible for handling resident grievances and lacked the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center as required.<br><br>On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed the posted information for the facility grievance procedure lacked the above required content. LALD-A stated registered nurse (RN)-C would be the person responsible for handling resident grievances.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 0 570 | | |

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| 0 570 | Continued From page 22<br>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.<br><br>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).<br><br>The findings include:<br><br>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.<br><br>On September 6, 2022, at approximately 2:03 p.m. during observation with licensed assisted living director (LALD)-A, LALD-A confirmed the current license was posted on a wall outside of the nursing office and was not displayed at the main entrance of the facility as required. LALD-A stated she was aware the license was to be displayed at the main entrance of the facility. LALD-A stated, "I don't know why there and not by the front entrance."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |

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| 0 620 | Continued From page 23 | 0 620 | | |
| 0 620 SS=E | 144G.42 Subd. 6 (a) Compliance with requirements for reporting ma<br><br>144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan.<br>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse and failed to complete a thorough investigation for occurrences of suspected abuse for three of three residents (R3, R2, R4).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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).<br><br>The findings include:<br><br>R3<br>The licensee lacked immediate report to MAARC of resident to resident altercations (physical and | 0 620 | | |

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| 0 620 | Continued From page 24 | 0 620 | | |

sexual) and lacked evidence of documentation of a thorough investigation of staff and resident interviews related to the altercations.

R3's diagnoses included dementia (memory loss).

R3's Resident Event Reports included the following:
-dated August 8, 2021, indicated resident to resident altercation. Resident #1 (R2) threw her walker at resident #12 (R3). Other outcome and follow up actions: Resident shows no injury from incident. When nurse asked him about it, R3 stated "it did not hit me".

-dated August 22, 2021, indicated resident to resident altercation. Resident #16 and resident #12 [R3] were in the back living room. Resident #16 asked R3 if he was sleeping with those women (referring to staff). Resident #16 was getting aggressive and agitated. Resident #16 started hitting R3 with her cane. Other outcome and follow up actions: per staff interviews from incident the two residents were separated. Resident shows no injury from being hit with the cane. Staff would separate the residents when staff noticed resident #16 becomes agitated.

-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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| 0 620 | Continued From page 25<br><br>(POA) was contacted and agreed relationship was ok as long as both resident parties agree the relationship was ok. Staff would intervene if needed due to all parties not agreeing yet to relationship between the two residents.<br><br>-dated September 10, 2021, indicated resident to resident altercation Resident #12 [R3] was sitting peacefully in the front when resident #16 started yelling at him and tried to lunge at him. This writer stepped in between and called for help. Resident were able to be redirected and altercation 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 become agitated with resident. Staff continue to watch for behaviors and intervene and separate the resident's if needed.<br><br>R3's record included the following MAARC reports:<br>-date and time submitted Wed. September 1, 2021, at 1:13 p.m. indicated on August 30, 2021, at 5:00 p.m. R3 and resident #16 have engaged in a sexual relationship with one another. Staff have observed a sexual act between the two residents. Both residents have consented to the relationship. Both residents' POAs are aware of the relationship and have agreed they may engage in the relationship.<br><br>On September 8, 2022, at 12:56 p.m. registered nurse (RN)-B stated she had no other MAARC reports for the above resident to resident altercations. RN-B stated both residents (R3 and resident #16) had a dementia diagnosis. RN-B was unable to identify who resident #16 was, and she would have to look for more information regarding the above Resident Event Reports. | 0 620 | | |

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| 0 620 | Continued From page 26<br>However, no further information was provided.<br><br>R2<br>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.<br><br>R2's diagnoses included dementia.<br><br>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.<br><br>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.<br><br>R4<br>The licensee lacked immediate report to MAARC | 0 620 | | |

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| 0 620 | Continued From page 27<br>of injury of unknown origin and lacked evidence of documentation of a thorough investigation of staff, resident and other resident interviews related to the injury of unknown origin to determine if abuse occurred.<br><br>R4's diagnoses included dementia.<br><br>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.<br><br>On September 8, 2022, at 10:46 a.m. RN-B stated she was "not sure why" the R4's injury was reported late to MAARC. RN-B stated that's "all I have," regarding documented information of R4's reported injury above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 620 | | |

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| 0 630 | Continued From page 28 | 0 630 | | |
| 0 630 SS=E | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>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).<br><br>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).<br><br>The findings include: | 0 630 | | |

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| 0 630 | Continued From page 29 | 0 630 | | |

R2
On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2.

R2's 90-day assessment dated August 9, 2021, indicated for "self preservation" R2 was a safety risk for abuse, neglect, and misappropriation and the description for the identified risk indicated "resident will be free from abuse and neglect until next review date. Based on interview from resident, observation and guardian and self preservation assessment, resident is considered vulnerable, but there are no signs of abuse or neglect. Resident does not appear to pose a threat to other vulnerable adults." The assessment further included an area of assessment for "shows signs of physical abuse to themselves or others" which included approaches for staff to implement when R2 would become upset and grab staff's arms.

The assessment failed to address R2's susceptibility to abuse by another individual, including other vulnerable adults as required.

R1
On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to complete R1's blood glucose check.

R1's 90-day assessment dated August 16, 2022, indicated for "self preservation" R1 was a safety risk for abuse, neglect, and misappropriation. The description for the identified risk indicated "resident will be free of abuse and neglect until next review day based on interview from resident observation, guardian and self preservation assessment, resident is vulnerable, but there are

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| 0 630 | Continued From page 30<br>no signs of abuse or neglect. Resident does not appear to pose a threat to other vulnerable adults." The assessment also included an area of assessment that indicated signs of physical and/or abuse to others, and indicated strategies for staff to implement when R1 became upset and exhibited verbal aggression.<br><br>The assessment failed to address R1's susceptibility to abuse by another individual, including other vulnerable adults as required.<br><br>On September 12, 2022, at 10:13 a.m. registered nurse (RN)-B stated resident's individual abuse prevention plans were integrated into the nursing assessments completed for residents. RN-B stated, "That's all we have" referring to the above content mentioned for assessment of abuse for R2 and R1. RN-B verified the assessment lacked an individualized review or assessment of R2 and R1's susceptibility to abuse by another individual, including other vulnerable adults as required<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number | 0 640 | | |

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| 0 640 | Continued From page 31<br>for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 17 residents receiving assisted living services, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On September 6, 2022, at 11:30 a.m. during observation of the facility, there were a total of four phones available for resident use. There was no 911 emergency number or the required MAARC information posted in common areas or near the telephone.<br><br>On September 6, 2022, at 2:03 p.m. licensed assisted living director (LALD)-A observed the | 0 640 | | |

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| 0 640 | Continued From page 32<br>areas of the facility with the surveyor and confirmed the 911 emergency number and the required MAARC information was not posted in common areas and near telephones. LALD-A stated she "was aware" of the requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect | 0 660 | | |

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| 0 660 | Continued From page 33<br>all residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>TB POLICY<br>The licensee lacked a written TB policy and procedure for the licensee's TB infection control program which addressed a team responsible for TB infection control, a facility TB risk assessment, written TB infection control procedures and health care worker (HCW) education.<br><br>TB RISK ASSESSMENT<br>The failed to ensure the licensee's TB Risk Assessment was dated and included all required information.<br><br>The licensee's TB facility risk assessment provided was undated and lacked documented information for incidence of TB. The risk assessment indicated the licensee was a low risk.<br><br>TB PLAN/EDUCATION<br>The licensee lacked a written TB infection control plan for the procedures to address early recognition and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. | 0 660 | | |

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| 0 660 | Continued From page 34<br><br>On September 12, 2022, at 12:22 p.m. registered nurse (RN)-B stated the licensee had no written policy and procedure for TB. RN-B stated she was not sure of the date she completed the licensee's TB Risk Assessment. RN-B verified the TB risk assessment lacked documented information for the incidence of TB.<br><br>The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should have an up-to-date TB infection control program that included: A team responsible for TB infection control; A facility TB risk assessment; Written TB infection control procedures; Health care worker (HCW) education. TB infection control team Identify a qualified person or a team of persons in your facility and assign them primary responsibility and authority for TB infection control. This person or team will conduct your setting ' s facility TB risk assessment; develop, implement, and enforce TB infection control policies (including HCW and resident TB screening); and ensure that HCWs receive adequate TB-related training and education. A TB infection control program should include the following: written TB infection control procedures. Procedures should address: Early recognition: All health care workers should know the signs and symptoms of TB and their role in their facility's TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. Referral: If your setting does not handle TB patients, transfer potentially infections TB patients to a setting that is equipped to evaluate and treat TB patients. TB training is required at time of hire for all health care workers | 0 660 | | |

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| 0 660 | Continued From page 35<br>and the content should focus on basic information: Your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. | 0 680 | | |

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| 0 680 | Continued From page 36<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the licensee failed to ensure an a written emergency disaster plan with required elements and was posted; failed to ensure emergency exit diagrams were posted and provided to residents and failed to ensure a written policy and procedure for missing residents included all required content. In addition, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all 17 residents, staff and any visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee lacked the following:<br>- a written emergency disaster plan that contained a plan for evacuation, which addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency;<br>- posting of an emergency disaster plan prominently;<br>- provided building emergency exit diagrams to all | 0 680 | | |

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| 0 680 | Continued From page 37<br><br>residents;<br>- posted emergency exit diagrams on each floor; and<br>- a written policy and procedure regarding missing tenant residents which addressed all required content; and<br>- Appendix Z (emergency preparedness) requirements<br><br>EMERGENCY DISASTER PLAN<br>On September 6, 2022, at 11:30 a.m. during a tour of the facility, an 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.<br><br>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 | 0 680 | | |

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| 0 680 | Continued From page 38 | 0 680 | | |

thunderstorm, winter storms, tornado, earthquake, bomb threat, terror alert, violent situation, flood and Crises Management for suspected abuse or neglect/caregiver misconduct and how to handle the media; however the plan did not address elements of sheltering in place, identified temporary relocation sites, and details staff assignments in the event of a disaster or an emergency.

EMERGENCY EXIT DIAGRAM
On September 6, 2022, at 11:30 a.m. during a tour of the facility, a diagram of the layout of the building (floor plan) was observed posted inside a glass enclosed case. The diagram lacked identification of exit locations from the building. There were no posted emergency exit diagrams in any other location of the building. At 2:03 p.m. observation of the facility with LALD-A, LALD-A confirmed the diagram of the layout of the building posted in the enclosed glass case did not identify exit locations from the building. LALD-A confirmed there were no other posted emergency exit diagrams in any other location of the building.

On September 7, 2022, at approximately 10:24 a.m. registered nurse (RN)-C stated, "We haven't been providing that", regarding providing building emergency exit diagrams to all residents.

MISSING RESIDENT PLAN
The licensee's Resident Elopement Policy dated August 2020, indicated "team members" to conduct missing resident search, search the building, courtyard, walk around the outside of the building area twice, looking in available vehicles, and walk up and down the street. If team members unable to locate the resident, contact police and also contact the director for assistance and additional support. The director should

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| 0 680 | Continued From page 39 | 0 680 | | |

contact the family. Team members need to be prepared to provide information to the police regarding the resident (information about the resident). Once the resident was located, the team members would take the resident's vital signs and complete a skin assessment to determine if any injuries. The director should notify responsible party as to where and when the resident was found and determine the amount of time team members should check the whereabouts of the resident. The timing of the check reflects how active the resident is.

The licensee lacked a missing resident plan which included the following:
-(1) identify a staff member for each shift who is responsible for implementing the missing resident, and ensure at least one staff member who is responsible for implementing the missing resident plan is on site 24 hours a day, seven days a week;
-(2) require that staff alert the staff member identified in sub item (1) immediately if it is suspected that a resident may be missing;
-(3) identify staff by position description who are responsible for searching for missing residents or suspected missing residents;
-(4) require that staff conduct an immediate and thorough search of the facility, the facility's premises, and the immediate neighborhood in each direction when a resident is suspected to be missing;
-(5) require that a suspected missing resident be considered missing if the resident is not located after staff complete the search in sub item (4);
-(6) require that staff immediately notify local law enforcement when a facility determines, under sub item (5) or otherwise, that a resident is missing;
-(7) require that staff immediately contact the

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| 0 680 | Continued From page 40<br>resident representatives and the resident's case manager, if applicable, when a resident is determined missing; and<br>-(8) require that staff cooperate with local law enforcement and provide any information that is necessary to identify and locate the missing resident.<br><br>On September 12, 2022, at LALD-A verified the licensee's Resident Elopement Policy dated August 2020, lacked the above required content.<br><br>APPENDIX Z REQUIREMENTS<br>The licensee lacked required information according to Emergency Preparedness: Appendix Z.<br><br>The licensee lacked the following required information according to Emergency Preparedness: Appendix Z:<br>- establish/maintain a comprehensive EP which describes the facility ' s approach to meeting health/safety/security needs of staff/residents addressing address how would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually;<br>- risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs), arrangements/contracts to re-establish utility services;<br>- document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation | 0 680 | | |

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| 0 680 | Continued From page 41<br>plans, staffing surges/shortages, back-up plans);<br>- identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care, identify which staff would assume specific roles in another's absence through succession planning and delegation of authority and qualified person authorized in writing to act in the absence of the administrator;<br>- a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;<br>- policy and procedure based on the EP risk assessment and communication plan;<br>- policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies;<br>- policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal;<br>- policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location;<br>- policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance;<br>- policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility;<br>- policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and | 0 680 | | |

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| 0 680 | Continued From page 42<br>secures/maintains availability of records;<br>- policy and procedure addressing use of volunteers, including the process/role for integration;<br>- policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents;<br>- policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT;<br>- develop a written communication plan;<br>- communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;<br>- communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; MN Office of Ombudsman for LTC and other sources of assistance;<br>- communication plan which includes primary and alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies;<br>- communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4);<br>- communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident | 0 680 | | |

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| 0 680 | Continued From page 43<br>command center, or designee; and<br>- communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives;<br>- develop and maintain an EP training and testing program;<br>- training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP;<br>- conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt form engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise;<br>- if part of a health care system consisting of separately certified healthcare facilities elects to have a unified and integrated EPP, they may choose to participate and if elected demonstrate each separately certified within the system actively participated in the development of the unified and integrated EPP. If elected the EPP demonstrates that each separately certified within the system actively participated in the development of the unified and integrated EPP, including developing/maintaining in a manner that takes into account each separately certified facility's unique circumstances, patient | 0 680 | | |

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| 0 680 | Continued From page 44<br><br>populations, and services offered; demonstrate each separately certified facility is capable of actively using the unified/integrated EPP and in in compliance with the program; include unified/integrated EP that meets requirements including documented community-based risk assessment, utilizing an all hazards approach; documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing and all hazards approach and include integrated policy and procedure that meet requirements set forth.<br><br>On September 7, 2022, at 8:59 a.m. LALD-A stated, "I don't have anything to do with the EP plan." LALD-A stated the EP plan was "done by compliance director in Wisconsin." LALD-A stated the only information she had regarding EP was the Emergency Management Plan dated January 7, 2017. LALD-A stated she "listened to calls about Appendix Z" provided by Minnesota Department of Health (MDH). LALD-A stated she was not aware of all of the requirements for Appendix Z. LALD-A stated "We believe we have everything in place except the hazardous risk assessment."<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 730 SS=E | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number; | 0 730 | | |

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| 0 730 | Continued From page 45<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this | 0 730 | | |

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| 0 730 | Continued From page 46<br>chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content and provided information to the receiving facility as required for one of one discharged resident (R3). In addition, the licensee failed to ensure required content of record for one of two residents (R2).<br><br>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).<br><br>The findings include:<br><br>R3<br>R3's record lacked a discharge summary to include:<br>- diagnoses;<br>- course of illness;<br>- allergies;<br>- treatments and therapies;<br>- pertinent lab, radiology, and consultation results; and<br>- a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status | 0 730 | | |

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| 0 730 | Continued From page 47<br><br>In addition, R3's record lacked documented evidence of providing the following information in writing to the receiving facility to include:<br>- the name and address of the facility, the dates of the resident's admission and discharge, and the name and address of a person at the facility to contact for additional information;<br>- names and addresses of any significant social or community contacts the resident has identified to the facility;<br>- the resident's most recent service or care plan, if the resident has received services from the facility; and<br>- the resident's current "do not resuscitate" order and "physician order for life-sustaining treatment," if any.<br><br>R3 began receiving services on December 2, 2020, and was discharged on April 11, 2022. R3's diagnoses included dementia.<br><br>R3's progress note dated April 11, 2022, indicated R3 was discharged from facility at 8:00 a.m. to another care facility for men. All medications were sent with. The medication log was filled out. All belongings were taken by "POA" (power of attorney) and the POA was going to meet resident at the other facility. Upon discharge resident was minimal assist with toileting, independent with ambulation and transfers, reminders with dressing and independent with eating at all meals.<br><br>R3's progress notes dated from November 1, 2021, through April 11, 2022, further indicated R3 had behaviors including increased agitation, taking other residents' food at meal times, relationship with a female resident, taking paper towels and putting them down sink drain and | 0 730 | | |

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| 0 730 | Continued From page 48<br>attempting to clog toilet, and sexual urges.<br><br>R2<br>R2's record lacked documented evidence of physician progress notes.<br><br>R2's Service Plan integrated into R2's 90-day assessment was dated August 9, 2022. R2's service plan indicated R2 received services which included p.m. snack, activity participation, alarm check, bathing, bowel assistance/monitoring, C-collar (neck brace), communication, compassionate touch, dressing, eating, environmental assistance, evacuation assist/supervise, fall risk monitoring, grooming assistance, hearing aid/glasses assistance, housekeeping, record 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 plan/assessment indicated for the service of eating assistance resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of C-collar, toe guards to right and left great toes, Ensure and mechanical soft diet.<br><br>R2's Task Administration Record dated September 2022, indicated the same and for C-collar staff are to ensure that the resident has C-collar on at all times. Please document here if resident removes C-collar. Has foam collar to | 0 730 | | |

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| | 30630 | A. BUILDING: _____ B. WING _____ | 09/12/2022 |

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| 0 730 | Continued From page 49<br>change into when taking a shower.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes.<br><br>On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating we push Ensure." At 9:32 a.m., ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."<br><br>R2's record lacked documented evidence of health information, including medical history and other relevant health records due to the licensee providing management of medication and treatment services.<br><br>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 the progress note dated April 11, 2021, was the only documented information of discharge summary for R3. RN-B stated, "I know the nurse had a conversation with facility staff", referring to the facility R3 was being discharged to. RN-B stated the licensee had no documentation in writing regarding what information was provided to the receiving facility. RN-B stated R2's record did not have any documented physician progress notes to provide to surveyor.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: | 0 730 | | |

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| 0 730 | Continued From page 50<br>Twenty-one (21) days | 0 730 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>On 9/06/2022, from approximately 12:30 PM to 2:00 PM, survey staff toured the facility with LALD-A. During the facility tour, survey staff observed a large accumulation of lint debris behind the dryer. | 0 800 | | |

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| 0 800 | Continued From page 51<br>LALD-A verbally confirmed survey staff observation during the facility tour.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION : Twenty-one (21) days | 0 800 | | |
| 0 930 SS=C | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br>(e) The contract must include a clear and conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;<br>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;<br>(4) the resident's right to obtain services from an unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R1). | 0 930 | | |

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| 0 930 | Continued From page 52<br><br>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).<br><br>The findings include:<br><br>R2's Resident 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.<br><br>R1's Residence and Services Agreement was signed was signed by LPN-G on October 6, 2021, and October 7, 2021, by R1's resident representative.<br><br>R2 and R1's Resident and Service Agreement indicated on page twelve (12), "The executive director of our housing senior living is responsible for ensuring that any complaints are addressed in a satisfactorily and timely manner and will maintain an open door policy for all residents and family (if resident so chooses family member's participation) to express any concerns."<br><br>R2 and R1's Resident and Service Agreement lacked the following required content:<br>-the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br><br>On September 12, 2022, at approximately 10:00 a.m. surveyor showed licensed assisted living | 0 930 | | |

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| 0 930 | Continued From page 53<br>director (LALD)-A, the missing contract requirement, LALD-A responded, "ok". LALD-A verified the licensee's Resident and Service Agreement was utilized for all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 930 | | |
| 0 940 SS=C | 144G.50 Subd. 2 (e; 5-7) Contract information<br><br>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:<br>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;<br>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);<br>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;<br>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;<br>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and | 0 940 | | |

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| 0 940 | Continued From page 54<br>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;<br>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and<br>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R1).<br><br>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).<br><br>The findings include:<br><br>R2's Resident 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.<br><br>R1's Residence and Services Agreement was signed was signed by LPN-G on October 6, 2021, and October 7, 2021, by R1's resident/representative.<br><br>R2 and R1's Resident and Service Agreement indicated on page fifteen (1) indicated "N. Medical | 0 940 | | |

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| 0 940 | Continued From page 55<br><br>Assistance Waivers and Housing Support Programs. The company's policy regarding medical assistance waivers and housing support programs is et forth in Exhibit 5 attached hereto." "Exhibit 5" indicated the licensee was "enrolled in the following State of Minnesota Medicaid waiver and assistance and housing support programs: Elder waiver, community Access for Disability Inclusion and Housing Support (formerly known as Group Residential Housing).<br><br>R2 and R1's Resident and Service Agreements lacked the following required content:<br>-whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;<br>-whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;<br>-a statement that residents may be eligible for assistance with rent through the housing support program; and<br>-a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.<br><br>On September 12, 2022, at approximately 10:00 a.m. licensed assisted living director (LALD)-A agreed that the above requirements were not included in the licensee's Resident and Service Agreement utilized for all residents. In reference to whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers, LALD-A responded, "I don't know what that means. We have a provider, or | 0 940 | | |

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| 0 940 | Continued From page 56<br>we would not get paid."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 940 | | |
| 0 950 SS=C | 144.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."<br><br>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. | 0 950 | | |

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| 0 950 | Continued From page 57<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to designated representative on a document separate from the contract and failed to ensure the contract included required content for two for two residents (R2, R1).<br><br>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).<br><br>The findings include:<br><br>R2's Resident 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.<br><br>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.<br><br>The first page of R2 and R1's Residence and Services Agreement contained verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information | 0 950 | | |

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| 0 950 | Continued From page 58<br><br>related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable" and page seventeen (17) of the Residence and Services Agreement included the same verbatim notice with an area for the designated resident to be listed; however, R2 and R1's records lacked evidence in writing of providing the verbatim notice on a document separate from the contact as required.<br><br>In addition, R2 and R1's Resident and Service Agreement lacked the required box the resident must initial if the resident declines to name a designated representative as part of the contract as required.<br><br>On September 12, 2022, at approximately 10:00 a.m. licensed assisted living director (LALD)-A stated, "OK" regarding the missing information noted above. LALD-A verified the licensee's Resident and Service Agreement was utilized for all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 950 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor | 0 970 | | |

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| 0 970 | Continued From page 59<br>include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings included:<br><br>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.<br><br>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.<br><br>The Residence and Services Agreement included on page eleven (11) the following:<br>-"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 applicable), renters' insurance and other | 0 970 | | |

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| 0 970 | Continued From page 60<br>insurance coverages in adequate amounts. We are not responsible for any damage or loss of any personal property belonging to you due to theft, fire, or any other cause, unless the loss or damage was caused by our community employees' gross negligence."<br>-"E. Responsibility for damages or injury to others. You are responsible for any injury or damage to persons or property caused by your acts or negligence. You agree to indemnify and hold harmless the community from all liability, loss, cost or damage for any injury or damage any person or property arising from or caused by your acts or negligence."<br>-"F. Act of other residents. The community is not responsible to you for any acts or negligence of another resident that may result in injury, illness or damage to your or your property. By signing this agreement, you release the community from all responsibility for injury or damage to you or your property arising from or caused by the acts or negligence of other residents or from the action of any employee or any provider."<br><br>On September 12, 2022, at approximately 10:00 a.m. licensed assisted living director (LALD)-A confirmed the licensee's Residence and Services Agreement for all residents included the above content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 970 | | |
| 0 990 SS=D | 144G.52 Subd. 2 Prerequisite to termination of a contract<br><br>(a) Before issuing a notice of termination of an | 0 990 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 990 | Continued From page 61<br>assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to:<br>(1) explain in detail the reasons for the proposed termination; and<br>(2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility.<br>(b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.<br>(c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting.<br>(d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility may attempt to schedule and participate in a meeting under this subdivision via telephone, video, or other | 0 990 | | |

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| 0 990 | Continued From page 62<br>means.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the opportunity of a meeting with a representative of the Office of Ombudsman for Long-Term Care before issuing a termination of services for one of one resident (R3).<br><br>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).<br><br>The findings include:<br><br>R3's record lacked documented evidence the licensee offered R3, and the resident's legal representative and designated representative sent a scheduled meeting with a representative of the Office of Ombudsman for Long-Term Care prior to expedited termination of R3's assisted living contract.<br><br>R3 began receiving services on December 2, 2020, and was discharged on April 11, 2022. R3's diagnoses included dementia.<br><br>R3's expedited termination of assisted living contract dated March 24, 2022, indicated per the licensee's "admission agreement the resident has engaged in conduct that substantially interferes with the rights, health of safety of other residents of the community (inappropriate sexual behavior). | 0 990 | | |

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| 0 990 | Continued From page 63<br><br>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."<br><br>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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days | 0 990 | | |
| 01030 SS=D | 144G.52 Subd. 6 Right to use provider of resident's choosing<br><br>A facility may not terminate the assisted living contract if the underlying reason for termination may be resolved by the resident obtaining | 01030 | | |

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| 01030 | Continued From page 64<br>services from another provider of the resident's choosing and the resident obtains those services.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to address if services form another service provider could be obtained to prevent termination of services for one of one discharged resident (R3).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R3's record lacked documented evidence the licensee attempted to resolve the underlying reason for termination by obtaining services from another provider of the resident's choosing and the resident obtains those services, prior to terminating the assisted living contract.<br><br>R3 began receiving services on December 2, 2020, and was discharged on April 11, 2022. R3's diagnoses included dementia.<br><br>R3's expedited termination of assisted living contract dated March 24, 2022, indicated per the licensee's "admission agreement the resident has engaged in conduct that substantially interferes with the rights, health of safety of other residents of the community (inappropriate sexual behavior). | 01030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01030 | Continued From page 65<br><br>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."<br><br>R3's progress note dated April 11, 2022, indicated was discharged from facility at 8:00 a.m. to another care facility for men. All medications were sent with. Medication log was filled out. All belongings were taken by "POA" (power of attorney) and the POA was going to meet resident at the other facility. Upon discharge resident was minimal assist with toileting, independent with ambulation and transfers, reminders with dressing and independent with eating at all meals.<br><br>R3's progress notes dated from November 1, 2021, through April 11, 2022, further indicated R3 had behaviors including increased agitation, taking other residents' food at meal times, consensual relationship with a female resident (#16), taking paper towels and putting them down sink drain and attempting to clog toilet, and sexual urges towards others.<br><br>R3's record lacked documented evidence of specifics regarding what cares R3 required as noted above in the expedited termination notice for "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 | 01030 | | |

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| 01030 | Continued From page 66<br>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 licensee could not meet for determination if another care provider would be able to meet R3's needs before termination of the assisted living contract or documented evidence of what the licensee attempted for resolution before termination of the assisted living contract.<br><br>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 R3 was discharged to a men's only facility. RN-B stated we had a female resident move over to our other house because of safety issue. RN-B stated we had interventions in place, but they did not work. RN-B stated we did ask R3's case worker if any other services were available. RN-B stated there were probably emails regarding conversation with the case worker about other services available; however, no other information was provided.<br><br>The licensee's Monitoring Resident Discharges Policy dated September 2021, indicated together the regional director of operations and director would troubleshoot ideas to keep the resident with facility if appropriate. Daily the director should be discussing resident concerns, including all resident to resident altercations, with the regional director of operations. Both the regional director of operations and the director should present goals or actions that need to take place to reduce or eliminate the behavior or concern.<br><br>TIME PERIOD FOR CORRECTIONS: | 01030 | | |

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| 01030 | Continued From page 67<br>Twenty-one (21) days | 01030 | | |
| 01040 SS=D | 144G.52 Subd. 7 Notice of contract termination required<br><br>(a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5.<br>(b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative.<br>(c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative.<br>(d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to send a copy of the termination | 01040 | | |

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| 01040 | Continued From page 68<br>notice to the Office of Ombudsman for Long-Term Care for one of one resident (R3).<br><br>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).<br><br>The findings include:<br><br>R3's record lacked evidence the licensee sent a copy of R3's expedited termination notice to the Office of Ombudsman for Long-Term Care.<br><br>R3 began receiving services on December 2, 2020, and was discharged on April 11, 2022. R3's diagnoses included dementia.<br><br>R3's expedited termination of assisted living contract dated March 24, 2022, indicated per the licensee, "admission agreement the resident has engaged in conduct that substantially interferes with the rights, health of safety of other residents of the community (inappropriate sexual behavior). 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." | 01040 | | |

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| 01040 | Continued From page 69<br><br>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 she would look for documented information if R3's expedited termination notice was sent to the Office of Ombudsman for Long-Term Care; however, no information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days | 01040 | | |
| 01050 SS=F | 144G.52 Subd. 8 Content of notice of termination<br><br>The notice required under subdivision 7 must contain, at a minimum:<br>(1) the effective date of the termination of the assisted living contract;<br>(2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale;<br>(3) a detailed explanation of the conditions under which a new or amended contract may be executed;<br>(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;<br>(5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;<br>(6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;<br>(7) information on how to contact the Office of Ombudsman for Long-Term Care to request an | 01050 | | |

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| 01050 | Continued From page 70 | 01050 | | |

advocate to assist regarding the termination;
(8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and
(9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the facility failed to provide a termination notice which contained all required information for one of one resident (R3).

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

The findings include:

R3 began receiving services on December 2, 2020, and was discharged on April 11, 2022. R3's diagnoses included dementia.

R3's expedited termination of assisted living contract was dated March 24, 2022, and indicated the effective date was April 11, 2022. The termination notice indicated per the licensee, "admission agreement the resident has engaged in conduct that substantially interferes with the rights, health of safety of other residents of the

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| 01050 | Continued From page 71<br>community (inappropriate sexual behavior). 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."<br><br>R3's termination notice lacked the following content:<br>- a detailed explanation of the conditions under which a new or amended contract may be executed;<br>- 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;<br>- a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55;<br>- the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination;<br>- information on how to contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination;<br>- information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and | 01050 | | |

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| 01050 | Continued From page 72<br>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."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days | 01050 | | |
| 01370 SS=E | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a | 01370 | | |

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| 01370 | Continued From page 73<br>licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-E, ULP-F).<br><br>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).<br><br>The findings include:<br><br>ULP-E had a hire date of May 11, 2022. ULP-E provided direct care and services to the licensee residents.<br><br>On September 7, 2022, at 8:13 a.m. ULP-E was | 01370 | | |

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| 01370 | Continued From page 74<br>observed to administer medications to R2 and applied toe guards to R2's right and left great toes.<br><br>ULP-E's record lacked documentation of completed training for the following:<br>-documentation requirements for all services provided;<br>-reports of changes in the resident's condition to the supervisor designated by the facility;<br>-maintenance of a clean and safe environment;<br>-appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>-training on the prevention of falls;<br>-standby assistance techniques and how to perform them;<br>-exercise, and treatment reminders;<br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br><br>ULP-E's record lacked documentation of completed competency for the following:<br>-appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>-standby assistance techniques and how to perform them<br><br>ULP-F had a hire date of August 11, 2022. ULP-F | 01370 | | |

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| 01370 | Continued From page 75<br>provided direct care and services to the licensee residents.<br><br>ULP-F's record lacked documentation of completed training for the following:<br>-documentation requirements for all services provided;<br>-reports of changes in the resident's condition to the supervisor designated by the facility;<br>-maintenance of a clean and safe environment;<br>-standby assistance techniques and how to perform them;<br>-exercise, and treatment reminders;<br>-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>-awareness of commonly used health technology equipment and assistive devices.<br><br>On September 12, 2022, at approximately 9:47 a.m. registered nurse (RN)-B verified ULP-E and ULP-F lacked the required training and demonstrated skill competency by an RN for the above topics. RN-B stated licensed practical nurse (LPN)-G had competency evaluated ULP-E for topics requiring competency evaluation. It was not completed by a RN as required.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01380 SS=D | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel | 01380 | | |

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| 01380 | Continued From page 76<br>providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for one of two unlicensed personnel (ULP-E).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-E had a hire date of May 11, 2022. ULP-E provided direct care and services to the licensee residents. | 01380 | | |

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| 01380 | Continued From page 77<br><br>On September 7, 2022, at approximately 1:00 p.m. ULP-E was observed to check R1's blood sugar.<br><br>ULP-E's record lacked documentation of completed training for the following:<br>-observing, reporting, and documenting resident status<br><br>ULP-E's record lacked documentation of completed competency for the following:<br>-reading and recording temperature, pulse, and respirations of the resident;<br>-safe transfer techniques and ambulation;<br>-range of motioning and positioning; and<br>-administering treatments as required<br><br>ULP-E's record included competency training documented by licensed practical nurse (LPN)-G on July 27, 2022, for CPAP (continuous positive airway pressure), catheter care, blood glucose testing, oxygen saturation (O2 SATS), oxygen, compression stockings and ace wrap; however, ULP-E's record lacked documented competency by a registered nurse (RN) for the treatments as required.<br><br>On September 12, 2022, at approximately 9:47 a.m. RN-B verified ULP-E lacked the required training and demonstrated skill competency for the above topics. RN-B stated LPN-G had competency evaluated ULP-E for topics requiring competency evaluation, but not by a RN as required.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the RN would ensure unlicensed personnel were trained, competent, and orientated to the resident | 01380 | | |

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| 01380 | Continued From page 78<br>whenever unlicensed personnel were to perform treatment management services for the resident. A RN may delegate nursing services to unlicensed team members only after determining that the unlicensed person was trained and competent and had been instructed in the proper methods to perform the procedures with respect to the specific resident. Including written instructions for performing the procedure for the resident in the resident record. Treatment or therapy tasks may be delegated or assigned by a licensed health professional to unlicensed personnel according to the licensed health professional's applicable licensing practice standards. When a treatment or therapy was delegated to unlicensed personnel, the RN "must" instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each treatment and determine that the unlicensed personnel had demonstrated the ability to competently follow the procedures.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01420 SS=F | 144G.62 Subd. 2 Delegation of assisted living services<br><br>(b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an | 01420 | | |

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| 01420 | Continued From page 79<br>unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of two unlicensed personnel (ULP-E, ULP-F) who performed delegated tasks.<br><br>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).<br><br>The findings include:<br><br>ULP-E had a hire date of May 11, 2022.<br><br>On September 7, 2022, at 8:13 a.m. ULP-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes.<br><br>ULP-E's record lacked documented training and competency evaluation for EZ stand lift (mechanical lift used to transfer a person form surface to surface) and BRODA chair (medical | 01420 | | |

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| 01420 | Continued From page 80<br>equipment used when sitting to reduce pressure and maintain mobility) use.<br><br>ULP-F had a hire date of August 11, 2022.<br><br>ULP-F's record lacked documentation for training and competency evaluation for BRODA chair use.<br><br>On September 12, 2022, at 9:12 a.m. RN-B stated, "Never heard of BRODA chair training." At 9:47 a.m., RN-B stated licensed practical nurse (LPN)-G had trained and competency evaluated ULP-E for delegated tasks. RN-B verified ULP-E had no training or competency evaluation by a RN for EZ stand lift. RN-B verified no ULP were trained or competency tested for BRODA chair use.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01420 | | |
| 01440 SS=D | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff | 01440 | | |

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| 01440 | Continued From page 81 | 01440 | | |

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 residents are affected or 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.

On September 7, 2022, at 8:13 a.m. ULP-E was

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| 01440 | Continued From page 82<br>observed to administer medications to R2 and applied toe guards to R2's right and left great toes.<br><br>On September 12, 2022, at 9:47 a.m. RN-B stated, "No, not by an RN," regarding ULP-E was supervised by an RN performing delegated tasks as required.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the RN would evaluate the team member's ability to perform the treatment at least thirty (30) days after trained to ensure the team member was completing the treatment appropriately and accurately.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01440 | | |
| 01620 SS=G | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must | 01620 | | |

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| 01620 | Continued From page 83 | 01620 | | |

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

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed a comprehensive reassessment for change in condition for two of two residents (R2, R1) related to falls, ER visits and change in status and failed to ensure the RN completed accurate assessment for two of two residents (R2, R1).

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

The findings include:

R2
R2's diagnoses included dementia and repeated falls.

R2's Service Plan integrated into R2's 90-day assessment was dated August 9, 2022. R2's

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| 01620 | Continued From page 84<br><br>service plan indicated R2 received services including p.m. snack, activity participation, alarm check, bathing, bowel assistance/monitoring, C-collar (neck brace), communication, compassionate touch, dressing, eating, environmental assistance, evacuation assist/supervise, fall risk monitoring, grooming assistance, hearing aid/glasses assistance, housekeeping, record 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 bandaid will be applied for protection. Toe guard to right toe will be held due to area until healed." The service plan/assessment indicated for the service of eating assistance resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure and mechanical soft diet.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. R2 was seated in a recliner in her room fully dressed. A walker was placed near R2's recliner and an alarm was in place on R2's recliner.<br><br>COMPREHENSIVE ASSESSMENT<br>R2's record lacked comprehensive assessment by the RN for change in condition related to falls and change in physical status. | 01620 | | |

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| 01620 | Continued From page 85<br><br>R2's record identified R2 had 17 falls between the dates of February 8, 2022, and August 18, 2022.<br><br>R2's observation notes/Resident Event Reports identified injuries were sustained, emergency room (ER) visits or hospitalization occurred related to falls for the following dates:<br>-dated February 8, 2022, sent to ER complaints of pain. No injuries noted. Diagnosed with urinary tract infection, antibiotic ordered.<br>-February 15, 2022, sent to ER to be evaluated for pain. No injuries and no change in orders.<br>-March 8, 2022, small cut on right elbow. Assessment of R2 by licensed practical nurse (LPN)-G identified skin tear right elbow measuring 2 centimeters (cm) x 1 cm and bruise right upper arm measuring 3 cm x 1.5 cm.<br><br>-April 30, 2022, injury to back of head large size bump. R2 was complaining of neck and back pain. Taken to ER. Hospitalized due to bilateral C2 fracture.<br>-May 17, 2022, transferred to ER for evaluation. Returned back to facility with no new orders. No injury from fall.<br>-June 4, 2022, at 8:20 a.m. taken to ER due to complaints of pain. Returned same day no new orders and CT scan (CAT scan/computerized tomography imaging) was performed with no new findings. On June 6, 2022, received call form ER another radiologist read CT scan stating R2 had an L1 compression fracture.<br>-June 4, 2022, at 6:13 p.m. continue Bactrim (antibiotic) for three more days, upcoming appointments with neurology and family practice.<br>-June 6, 2022, bruising to right elbow.<br>-July 24, 2022, discoloration on right side of forehead and right knee. Resident said head hurt. Sent to ER. Returned from ER, no bruising noted and no change in orders. | 01620 | | |

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| 01620 | Continued From page 86 | 01620 | | |

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 hemorrhoids.
-dated 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 down.
-dated June 2, 2022, staff reported resident urine is odorous and dark. Staff were encouraged to push fluids.
-August 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 stomach.
-dated 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

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| 01620 | Continued From page 87<br>evidence of comprehensive assessment by the RN for change in condition related to falls and physical change in status.<br><br>On September 6, 2022, at 10:27 a.m. during the entrance conference registered nurse stated the process if a fall occurred was "first assess range of motion and vital signs to determine if need to transport out or assisted. Family and medical doctor are notified. A Resident Event form is filled out and the nurse reviews the form and implements interventions. Nurse assesses if present. If the nurse is not present, then the RCA [resident care attendant] follows a list and the next time the nurse is in the building the nurse would assess the resident. The nurse on call is notified after every fall." RN-B stated for the process of ER visits "the nurse receives a call when coming back and if the nurse is not in the building the on call nurse gets called. We all have access to ECP [computer system] to determine to see the resident or not and can update information in the care plan." RN-B stated upon return from hospitalization, "if gone 24 hours a full assessment" (comprehensive) would be completed. RN-B stated a full assessment was not completed with an ER visit, but a review of the ER visit was completed.<br><br>On September 12, 2022, at 10:13 a.m. RN-B stated, after falls LPN-G was updating assessments for R2. RN-B stated, "No, I am not after falls" completing comprehensive assessments of R2 when there were changes in condition related to falls. RN-B stated, "The LPN was doing them", referring to assessments. RN-B stated she had completed a comprehensive assessment on R2 following return form the hospital on May 13, 2022. RN-B stated there were no comprehensive assessment completed | 01620 | | |

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for change in status as noted above for the dates of May 24, 2022, June 2, 2022, August 25 and 26, 2022. RN-B stated, "My last assessment for [R2] was August 9".

ACCURATE ASSESSMENT
The license failed to ensure accurate assessment by the RN.

On September 7, 2022, at 8:13 a.m. R2's bed was observed to have a grab bar (physical assist device) in place on the upper right side of the bed.

On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure."

R2's 90-day assessment dated August 9, 2022, indicated "n/a" (not applicable) for "how much fluid (water, juice, coffee, tea, milk, etc.) is consumed each day" and "additional assistive device" was not addressed (marked) for the listed item of "repositioning bar".

On September 12, 2022, at 10:13 a.m. RN-B verified the areas on the assessment for fluid intake and assistive device was not addressed appropriately on the assessment.

R1

R1 has diagnoses that include type 2 diabetes, mild intellectual disability, heart failure, chronic obstructive pulmonary disease, hypertension (high blood pressure), insomnia and nicotine dependence.

R1 received services including medication

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management, blood sugar checks, dressing/grooming reminders, stand by assist for showers, skin care, behavior management, and alcohol/ tobacco supervision.

SMOKING OBSERVATION

R1's Our House Assessment MN dated August 16, 2022, in section "17. Habits/Routines" indicated check mark next to sentence, "Smokes/chews tobacco, alcohol consumption, recreational drug use supervision needed- 1 assist outside." The section labeled "Alcohol/Tobacco-Supervision or Assistance" included the following content: "(R1) is allowed to go outside and smoke. Staff will let resident out on the patio. Staff will then light his cigarette. (R1) has exhibited safe smoking practices and is able to let himself back in the facility after smoking. If problems arise from smoking, ULP to notify director. Cigarettes will be locked in the med closet at all times. Guardian will supply cigarettes or resident will roll his own cigarettes."

On September 7, 2022, at approximately 11:15 a.m. ULP-E stated that the process for R1 to receive a cigarette was for him to ask staff, staff would get a cigarette from the medication room (where they were stored), escort R1 to the patio area and assist with lighting cigarette. He was allowed to smoke outside independently once the cigarette was lit.

On September 7, 2022, at approximately 11:25 a.m. R1 was observed smoking a cigarette as he sat on a bench at the facility's outside patio. The surveyor observed a plastic trash can with a plastic trash liner inside the can. The plastic trash can contained multiple extinguished cigarette butts and some empty cigarette boxes. The

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| 01620 | Continued From page 90<br>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.<br><br>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 butt.<br><br>On September 7, 2022, at approximately 11:35 a.m. R1 indicated that he placed his 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.<br><br>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 trash on the ground". RN-B and RN-C confirmed there were two other receptacles for cigarette butts the staff were using, and would immediately move one of them next to the bench for the residents to use. | 01620 | | |

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| 01620 | Continued From page 91<br><br>ASSESSMENTS<br><br>On March 30, 2022, at 1:00 p.m. LPN-G provided an "event and concern entry" in R1's record, and indicated R1 was evaluated in the Emergency Room for concerns with blood from penis with "copious amount of blood found on the floor in front of the toilet and inside the toilet." R1 was sent by ambulance to the Emergency Room (ER), and returned to the facility that same day with with a new antibiotic order for Cefdinir for a suspected urinary tract infection.<br><br>On March 30, 2022, "Our House Assessment MN Other: update to ER visit", as completed by LPN-G indicated "no identified items" in assessment section identified for areas of concern for "Bladder." Areas that included "Urinary tract infections (UTI's) and other genitourinary concerns" were left blank. No other indication of new blood or ER trip was included in this assessment.<br><br>On September 12, 2022, at approximately 12:00 p.m. RN-B confirmed the assessment was not completed by a RN as required.<br><br>An "Observation" entry on June 9, 2022, at 8:30 a.m. by LPN-G, indicated R1 was evaluated in the ER for a nose bleed and headache reported to be rated at "6 and getting worse". No follow up paperwork was initially returned to the facility from the ER. LPN-G documented contact was made to request a discharge summary and any new prescriber orders. R1's record included a document dated June 7, 2022, named "After visit summary" from that ER visit and included instructions and medication management related | 01620 | | |

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| 01620 | Continued From page 92<br>to R1's nosebleed.<br><br>R1's record indicated that R1 had a follow up appointment on June 14, 2022, where he was being evaluated by a new provider who provided changes in medication orders that included: discontinue aspirin, rose geranium nasal spray, Neil med sinus rinse and Vaseline to nares. The orders were noted by LPN-G on June 14, 2022.<br><br>R1's record lacked required RN assessment following a change in condition after R1's ER visit on June 7, 2022, or follow up appointment on June 14, 2022.<br><br>On September 12, 2022, at approximately 12:00 p.m. RN-B confirmed R1's record lacked the required RN assessment following a change in condition.<br><br>ACCURATE ASSESSMENT<br><br>On September 7, 2022, at approximately 8:45 a.m. ULP-E was observed to administer insulin to R1 as subcutaneous injection into his abdomen. R1's Our House Assessment MN-90 day assessment dated August 16, 2022, indicated that R1 assisted with self-administration of insulin. The assessment included a statement in section labeled "Additional Medication Needs" with check mark by selection indicating "Monitoring of self administered insulin (doctor orders) or medications (RN must evaluate resident's ability to self administer meds)." R1's assessment lacked clear indication of self-administration versus staff administration for insulin.<br><br>The August Medication Administration Record | 01620 | | |

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(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 preference), risk for psychological stress and unsuccessful previous placements.

On September 12, 2022, at approximately 12:00 p.m. with RN-B and LALD-A. RN-B confirmed the assessment dated August 16, 2022, lacked complete and accurate information. LALD-A stated that the 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 indication of how R1's insulin is given. LALD-A and RN-B

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| 01620 | Continued From page 94<br>confirmed the missing required assessment elements as listed above.<br><br>The licensee's Care Plans Policy dated April 2022, indicated directors were to ensure that appropriate strategies were in place for for any potential harmful behavior patterns such as fall risk. Any time a resident returns from hospital, nursing home or other provider, the director/RN was required to complete a reassessment of the resident prior to the resident returning. The residents ISP was to be update to reflect all changes of condition for the resident. "You can never do a care plan revision without performing an assessment first." Insufficient changes of condition would be any change from the resident's baseline as noted on ISP. Other significant changes of condition would need to be updated each time they are noted to have occurred, as it was expected that each incident, a plan was put into place to ensure resident safety and ensure adequate care for the resident. Significant changes in conditions may include falls, injuries, bruising, weight loss or gain, behavioral incidents, whether they are verbal, physical, or sexual in nature, any elopement attempts, wandering, inappropriate toileting. The ISP was required to be updated immediately upon knowledge of the information of a change of condition. If the director/RN was not in house to update the ISP, the director/RN was to inform a team member to write the intervention and information on the staff ISP in the ISP binder in the common area, document an observation on the resident to include intervention, and review and sign off on the ISP staff review form review of the update. The director//RN , upon return to the location would update the ISP in the ECP system.<br><br>No further information was provided. | 01620 | | |

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| 01620 | Continued From page 95<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01620 | | |
| 01640 SS=E | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the service plan was revised with changes in services for two of two residents (R2, R1).<br><br>This practice resulted in a level two violation (a | 01640 | | |

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| 01640 | Continued From page 96<br>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).<br><br>The findings include:<br><br>R2<br>R2's service plan lacked revision for the treatment services C-collar (neck brace), toe guards to right and left great toes, Ensure (supplement) and mechanical soft diet.<br><br>R2's diagnoses included dementia and repeated falls.<br><br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated R2 required total assistance with dressing and undressing. C-collar used due to fracture. Attempts to take off C-collar. Skin care treatment instructions indicated R2 was at risk for skin breakdown due to C-collar. Daily skin check due to C-collar use. 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 plan/assessment indicated for the service of eating assistance resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure and mechanical soft diet. | 01640 | | |

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| 01640 | Continued From page 97<br><br>R2's Task Administration Record dated September 2022, indicated the same.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. R2 was seated in a recliner in her room fully dressed and did not have a C-Collar in place. The skin on R2's right great toe was intact (no blister was observed).<br><br>On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m., ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."<br><br>R2's observation notes indicated the following:<br>-dated April 25, 2022, resident is now on a mechanical soft diet, all foods should be soft. A mechanical soft diet guide is hanging in the kitchen for staff education.<br>-dated May 26, 2022, when putting on toe guard, I noticed a cut on big toe.<br>-dated June 28, 2022, family did bring Ensure bottles for resident. Will request for this to be given one time daily. Awaiting doctor orders.<br><br>R2's record included the following:<br>-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 physician.<br>-prescriber order dated June 10, 2022, indicated plan to wear collar six weeks then repeat x-ray. Plan a brace wean potential at that time. | 01640 | | |

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| 01640 | Continued From page 98<br>However, no further information was provided for prescriber's order regarding if the collar was discontinued or not.<br><br>R2's record lacked documented evidence of a prescriber's order for the toe guards, ensure and mechanical soft diet.<br><br>R2's service plan lacked revision for the treatment services of toe guards to right and left great toes, Ensure and mechanical soft diet.<br><br>On September 12, 2022, at 10:13 a.m. registered nurse (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." RN-B verified R2's service plan lacked the above.<br><br>R1<br>The licensee lacked revision of R1's service plan for the treatment service of as needed (PRN) blood sugar checks.<br><br>R1's diagnoses included type two (2) diabetes, mild intellectual disability, heart failure, chronic obstructive pulmonary disease (lung disease), hypertension (high blood pressure) and insomnia.<br><br>R1's Service Plan integrated into R1's 90-day assessment dated August 16, 2022, indicated R1 received treatment services including medication management and blood sugar checks. R1's Assessment/Service plan dated August 16, 2022, in section "Wellness Monitoring/Treatments" indicated "Is on scheduled insulin and blood sugar checks four (4) times daily."<br><br>On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to check R1's blood | 01640 | | |

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| 01640 | Continued From page 99<br>sugar.<br><br>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."<br><br>R1's records lacked a prescriber order for blood sugar checks, but included provider orders for supplies of lancets and alcohol pads (used to check blood sugar) for up to eight (8) times daily.<br><br>R1's Service Plan lacked the treatment service of PRN blood sugar checks.<br><br>On September 9, 2022, at approximately 10:22 a.m. registered nurse (RN)-C verified R1's service plan lacked revision for providing the additional as needed blood sugar testing.<br><br>The licensee's Contents of "MN Service Plan Content Policy" dated with revision of June 2020, indicated "All residents/tenants have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN). Contents of the service place are established after completion of a full individualized initial assessment and each subsequent reassessment. This included " a Description of home care services including nursing and medication management services, treatments, and/or therapy services provided by our agency and the frequency of each service according to the resident/tenants current assessment and preferences." | 01640 | | |

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| 01640 | Continued From page 100<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) days | 01640 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced | 01650 | | |

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| 01650 | Continued From page 101<br>by:<br>Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R2, R1).<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's diagnoses included dementia and repeated falls.<br><br>R2's Service Plan integrated into R2's 90-day assessment was dated August 9, 2022. R2's service plan indicated R2 received services which included p.m. snack, activity participation, alarm check, bathing, bowel assistance/monitoring, C-collar (neck brace), communication, compassionate touch, dressing, eating, environmental assistance, evacuation assist/supervise, fall risk monitoring, grooming assistance, hearing aid/glasses assistance, housekeeping, record 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 | 01650 | | |

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| 01650 | Continued From page 102<br>and Band-aid will be applied for protection. Toe guard to right toe will be held due to area until healed." The service plan/assessment indicated for the service of eating assistance resident was in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure and and mechanical soft diet.<br><br>R2's Task Administration Record dated September 2022, identified staff documented for providing the services as indicated on R2's service plan.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. R2 was seated in a recliner in her room fully dressed and did not have a C-Collar in place. The skin on R2's right great toe was intact (no blister was observed).<br><br>On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m., ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."<br><br>R2's Service Plan lacked the following:<br>-a description of the services to be provided (toe guards, ensure, mechanical soft diet), the fees for services (each service)<br>- a contingency plan that includes: the action to be taken if the scheduled service cannot be provided | 01650 | | |

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| 01650 | Continued From page 103<br>R1<br>R1's diagnoses included type two diabetes, mild intellectual disability, heart failure, chronic obstructive pulmonary disease, hypertension (high blood pressure), insomnia and nicotine dependence.<br><br>R1's Service Plan dated August 16, 2022, indicated R1 received services which included blood sugar checks, dressing/grooming reminders, stand by assist for showers, skin care, behavior management, and alcohol/ tobacco supervision.<br><br>On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to assist R1 with blood sugar check in his room.<br><br>R1's Service Plan (as integrated within RN assessment) indicated blood sugars would be completed four times daily.<br><br>R1's August and September 2022 Medication Administration Record indicated staff were signing for providing the services of blood sugar checks up to eight times daily with scheduled times of 7:00 a.m. 11:00 a.m. 5:00 p.m. and 8:00 p.m. and R1's August and September 2022 MAR contained an as needed (PRN) section that indicated direction for "8 times daily as needed."<br><br>R1's Service plan lacked inclusion of as needed (PRN) blood sugar checks.<br><br>R1's Service Plan lacked the following:<br>- description of services to be provided (as needed blood sugar checks), the fees for the services (each service); and<br>- a contingency plan that includes: the action to be taken if the scheduled service cannot be | 01650 | | |

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| 01650 | Continued From page 104<br>provided.<br><br>On September 12, 2022, at 10:13 a.m. registered nurse (RN)-B verified R1 and R2's service plan lacked the above content. Licensed assisted living director (LALD)-A confirmed the licensee had a contract with an agency (alternate staffing) who would be able to provide care services. RN-B and LALD-A confirmed the contracted agency was not indicated on the contingency plan for an outside service provider. LALD-A verified all residents' service plans would lack some of the content required as above.<br><br>The licensee's Contents of Service Plans MN policy revised June 2020, indicated service plans would include the required content as according to the assisted living statute 144G.70 Subd.4.(f.).<br><br>No Further information provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01710 SS=E | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to ensure | 01710 | | |

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| 01710 | Continued From page 105 | 01710 | | |

reassessment of medication management services at a minimum annually 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:

R2 had an admission date of July 27, 2021, with diagnoses including dementia and repeated falls.

R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated R2 received services which included medication management.

On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2.

R2's medication assessment integrated into R2's 90-day assessment dated August 9, 2022, indicated "company to administer all medications." Current medications are on "MAR [medication administration record]. Side effects and diagnosis are in medication portion of extended Care Pro. List all medications including prescriptions, over the counter medications and supplements. Include name, dosage, route, frequency, diagnosis, side effects, contraindications and necessary interventions,

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| 01710 | Continued From page 106<br>and adverse reactions and necessary interventions. See MAR. List any medication allergies: NSAIDS [used to relieve pain/reduce inflammation]. Medication assessment of the potential for medication diversion and interventions to prevent diversion. n/a [not applicable]".<br><br>R2's MAR dated August 2022, indicated staff were administering one medication used to treat gout, four supplements, one used to treat hypothyroidism, one used for sleep, four used for constipation, one used for depression, one used for pain, one used to strengthen bones, three used for dry eyes, one used for restlessness and one used for sore throat. The MAR lacked side effects, contraindications and necessary interventions, and adverse reactions and necessary interventions and indications for some of the medications as indicated on R2's medication assessment.<br><br>R2's record lacked a medication reassessment by the registered nurse (RN) conducted face-to-face with the resident, with the following required content:<br>-documentation the assessment was conducted face-to-face with the resident; and<br>-identification and review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues<br>-identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. | 01710 | | |

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| 01710 | Continued From page 107<br><br>On September 12, 2022, at 10:13 a.m. RN-B verified R2's medication reassessment lacked the above and R2's record lacked documentation by the RN for review of administration of medications being given to R2 regarding if there were any side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br><br>R1<br>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.<br><br>R1's Service Plan integrated into R1's 90-day assessment dated August 16, 2022, included medication management.<br><br>On September 7, 2022, at 8:45 a.m. ULP-E was observed to administer medications to R1.<br><br>R1's medication assessment integrated into R2's 90-day assessment dated August 16, 2022, indicated "company to administer all medications." Current medications are on "MAR. Side effects and diagnosis are in medication portion of extended Care Pro. 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 MAR. List any medication allergies: no known allergies. Medication assessment of the potential for medication diversion and interventions to prevent diversion. n/a [not applicable]". | 01710 | | |

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| 01710 | Continued From page 108<br><br>R1's MAR dated August 2022, indicated staff were administering two medications for hypertension (high blood pressure), one for high cholesterol, three for heart failure/chest pain, one for acid reflux, five for type 2 diabetes, two for sleep, two for agitation/depression, three for COPD, two for nasal dryness/nose bleeds, and one for thick toenails.<br><br>R1's record indicated medication additions/changes:<br>-June 7, 2022, use of Afrin nasal spray as needed for nose bleeds<br>-August 2, 2022, increased dose for quetiapine (used for agitation and insomnia).<br><br>R1's record lacked a medication reassessment by the RN conducted face-to-face with the resident, with the following required content:<br>-documentation the assessment was conducted face-to-face with the resident; and<br>-identification and review of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and<br>-identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>On September 12, 2022, at approximately 12:00 p.m. RN-B verified R1's medication reassessment lacked the above and R1's record lacked documentation by the RN for review of administration of medications being given to R1 | 01710 | | |

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| 01710 | Continued From page 109<br>regarding if there were any side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the RN would evaluate the effectiveness of the medications and identify any drug to drug interaction and untoward or reported side effects.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01710 | | |
| 01730 SS=E | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that | 01730 | | |

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| 01730 | Continued From page 110<br>medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure an individualized medication management plan to include all required content for two of two residents (R2, R1).<br><br>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). | 01730 | | |

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| 01730 | Continued From page 111<br><br>The findings include:<br><br>R2<br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated R2 received medication management.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2.<br><br>R2's individualized medication management record integrated into R2's 90-day assessment dated August 9, 2022, indicated company to administer all medications. Current medications are on "MAR" (medication administration record). Side effects and diagnosis are in medication portion of extended Care Pro. 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 MAR. List any medication allergies: NSAIDS (used to relieve pain/reduce inflammation). Medication assessment of the potential for medication diversion and interventions to prevent diversion. n/a (not applicable).<br><br>R2's MAR dated August 2022, indicated staff were administering one medication used to treat gout, four supplements, one used to treat hypothyroidism, one used for sleep, four used for constipation, one used for depression (duloxetine), one used for pain, one used to strengthen bones (alendronate), three used for dry eyes, one used for restlessness and one used for sore throat. The MAR lacked addressing side | 01730 | | |

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| 01730 | Continued From page 112 | 01730 | | |

effects, contraindications and necessary interventions, and adverse reactions and necessary interventions and indications for some of the medications as indicated on R2's medication assessment dated August 9, 2022. The MAR indicated "okay to crush" for some medications.

R2's MAR indicated "okay to crush" for duloxetine (used for depression); however, according to the website medlineplus.gov directed "swallow the delayed-release capsules whole; do not split, chew, or crush them. Do not open the delayed-release capsules and mix the contents with liquids or sprinkle the contents on food."

R2's MAR lacked direction for administration of alendronate (used for bone strength); according to the website medlineplus.gov "You must take alendronate just after you get out of bed in the morning, before you eat or drink anything. Never take alendronate at bedtime or before you wake up and get out of bed for the day. After you take alendronate, do not eat, drink, or take any other medications (including vitamins or antacids) for at least 30 minutes. Do not lie down for at least 30 minutes after you take alendronate. Sit upright or stand upright until at least 30 minutes have passed and you have eaten your first food of the day. If you are taking the alendronate tablets, swallow the tablet with a full glass (6 to 8 ounces) of plain water. Never take alendronate tablets with tea, coffee, juice, milk, mineral water, sparkling water, or any liquid other than plain water. Swallow the tablets whole; do not split, chew or crush them. Do not suck on the tablets." R2's prescriber orders for alendronate dated June 10, 2022, included the direction of take with eight ounces of water, on an empty stomach, remain upright 30 minutes. The MAR lacked the

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| 01730 | Continued From page 113<br>direction for the alendronate medication as per prescriber orders.<br><br>In addition R2's MAR lacked parameters for hours apart for systane eye drops (one drop both eyes four times daily as needed (PRN) for dry eyes), parameters for the amount to give for Metamucil powder (mix 1-2 rounded tablespoons in beverage and take once daily) and parameters for which PRN eye drop medication (Systane or artificial tears) to give first.<br><br>R2's individualized medication management record lacked the following:<br>-a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>-documentation of specific resident instructions relating to the administration of medications;<br>-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>-identification of medication management tasks that may be delegated to unlicensed personnel;<br>-any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>On September 12, 2022, at 10:13 a.m. registered nurse (RN)-B verified R2's individualized medication management record lacked the above content.<br><br>R1<br>R1's Service Plan integrated into R1's 90-day assessment dated August 16, 2022, indicated R1 | 01730 | | |

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| 01730 | Continued From page 114 | 01730 | | |

received services including medication management.

On September 7, 2022, at 8:45 a.m. ULP-E was observed to administer medications to R1 including:
aspart insulin flex-pen, 10 units with breakfast, subcutaneously (under skin in fatty tissue) in abdomen.

R1's medication assessment integrated into R2's 90-day assessment dated August 16, 2022, indicated "company to administer all medications." Current medications are on "MAR. Side effects and diagnosis are in medication portion of extended Care Pro. 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 MAR. List any medication allergies: no known allergies. Medication assessment of the potential for medication diversion and interventions to prevent diversion. n/a [not applicable]".

R1's MAR dated August 2022, indicated staff were administering two medications for hypertension (high blood pressure), one for high cholesterol, three for heart failure/chest pain, one for acid reflux, five for type 2 diabetes, two for sleep, two for agitation/depression, three for COPD (congestive obstructive pulmonary disorder), two for nasal dryness/nose bleeds, and one for thick toenails.

R1's August 16, 2022, assessment in section labeled "additional medication needs" indicated a check mark in box next to statement, "monitoring

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| 01730 | Continued From page 115<br>of self-administered insulin (doctors's orders) or medications (RN must evaluate resident's ability to self administer meds."<br>R1 does not self-administer his insulin and relies on staff to administer.<br><br>R1's individualized medication management record lacked the following:<br>-a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>-documentation of specific resident instructions relating to the administration of medications;<br>-identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>-identification of medication management tasks that may be delegated to unlicensed personnel;<br>-any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions<br><br>On September 12, 2022, at 12:15 p.m. RN-B verified R1's assessment included inaccurate information regarding insulin self-administration as staff administered the injection. RN-B stated "this is what the company does, and this wording needs to be removed." Additionally, RN-B verified R1's individualized medication management record lacked the above content.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01730 | | |

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| 01750 | Continued From page 116 | 01750 | | |
| 01750 SS=I | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating nursing tasks, the one of one unlicensed personnel (ULP-E) was trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to perform the tasks with employee record reviewed. This resulted in an immediate correction order on September 9, 2022, at approximately 10:40 a.m.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include: | 01750 | | |

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| 01750 | Continued From page 117<br><br>ULP-E<br>ULP-E was hired May 11, 2022, and provided direct care services to residents.<br><br>On September 7, 2022, at 8:13 a.m. ULP-E was observed to administer oral medications and an eye drop medication to R2. At the time, ULP-E stated licensed practical nurse (LPN)-G trained her to do medication administration. When asked if a registered nurse (RN) had trained and observed her complete medication administration to determine competency, ULP-E stated, "No."<br><br>On September 7, 2022, at 8:45 a.m. ULP-E was observed to administer oral medications, nasal medication and insulin by injection via an insulin pen to R1.<br><br>R1 and R2's medication administration records (MARs) for September 2022, indicated ULP-E administered medications on September 4, 5, and 7, 2022.<br><br>ULP-E's record included the following:<br>-Orientation Checklist for Medication Administration dated July 27, 2022, signed by LPN-G on July 27, 2022.<br>-medication competency dated July 27 2022, signed by LPN-G.<br>-certificate for "medication Administration" dated July 27, 2022, signed by LPN-G.<br>-Medication Observation and Evaluation Forms signed by LPN-G for the dates of August 9, 11, 12, 2022.<br>-Skill Competency Medication Administration Routes dated July 27, 2022, signed by LPN-G on July 27, 2022, for oral, sublingual, buccal, topical, eye drops, eye ointment, ear drops, transdermal patch application, transdermal patch removal, | 01750 | | |

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| 01750 | Continued From page 118<br>nasal spray, vaginal and rectal suppository route procedures.<br>-Skill Competency Medication and Treatment Nebulizer and Inhalers dated July 27, 2022, signed by LPN-G on July 27, 2022, for metered dose inhaler, dry powder inhale rand nebulizer procedures.<br>-Skill competency Medication and Treatment Administration Insulin Administration dated July 27, 2022, and signed by LPN-G on July 27, 2022, for insulin administration procedure.<br>-Skill competency Medication and Treatment Administration Insulin Pens dated July 27, 2022, and signed by LPN-G on July 27, 2022, for insulin pens procedure.<br>-Medication Management and Administration Training Completion Form dated July 27, 2022, and signed by LPN-G for "Step 2: After Attending 8 Hour Medication Training Class" on August 2, 3, and 5, 2022, and for "Team member was observed by director/home manager correctly passing medications/completed buddy check process" on August 9, 11 and 12, 2022.<br>-Educare (electronic training program) Medication Administration "overview, routes" dated July 19, 2022.<br>-Educare Medication and Treatment "Insulin, Insulin pen, nebulizer and Inhalers" dated July 20, 2022.<br><br>ULP-E's employee record lacked documentation of medication administration demonstrated competency by a RN prior to administering medications to R1 and R2.<br><br>On September 8, 2022, at 2:04 p.m. RN-B verified LPN-G had trained ULP-E for medication administration.<br><br>On September 9, 2022, at 10:07 a.m. RN-B | 01750 | | |

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| 01750 | Continued From page 119<br><br>verified LPN-G had completed competency by herself with ULP-E for medication administration (without RN-B present). RN-B stated LPN-G had "the delegation to do that" by her. RN-B stated for delegation of LPN-G to do competency with ULP, "I've shown her how to do the skill." At 10:54 a.m., RN-B provided "LPN Competency for a Delegation TN Nursing Task" dated September 27, 2021, for "assist with Educare training, skill competencies and evaluation, nursing procedures" and indicated LPN-G "has been deemed competent for delegated nursing task/procedures identified above" and was signed by LPN-G and RN-B on September 27, 2021. However, there were no specific details of what the "assist with Educare training, skill competencies and evaluation, nursing procedures" were.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services policy dated revised June 2020, indicated "The RN will ensure that unlicensed personnel are trained, competent, and orientated to the resident/tenant whenever unlicensed personnel are to perform medication management services or treatments for the resident/tenant. The RN effectively "delegates" by transferring the responsibility for the performance of a nursing task in a specific situation to another nursing team member who is competent to perform the task while the RN retains the accountability for the outcome. Using their professional judgement, RNs may delegate nursing tasks to LPN's or unlicensed personnel (team member) categories such as RCA's, assistance directors, LEC's, or cooks, consistent with the Nurse Practice Act, the MN home care requirements, accepted nursing practice, and the five (5) rights of delegation: 1. | 01750 | | |

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| 01750 | Continued From page 120<br>Right task to be delegated 2. Under the right circumstances 3. The right person to the task 4. The right directions and communication 5. The right supervision to ensure the task is carried out safely."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE<br><br>On September 9, 2022, at 3:50 p.m. immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains.<br><br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for administration of medications for one of two residents (R2).<br><br>R2<br>R2's record lacked specific instructions for administration of medications, which was delegated to unlicensed personnel.<br><br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated R2 received services including medication management.<br><br>On September 7, 2022, at 8:13 a.m. ULP-E was observed to administer medications to R2.<br><br>R2's individualized medication management record integrated into R2's 90-day assessment dated August 9, 2022, indicated company to administer all medications. Current medications are on "MAR" (medication administration record). | 01750 | | |

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| 01750 | Continued From page 121<br><br>Side effects and diagnosis are in medication portion of extended Care Pro. 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 MAR. List any medication allergies: NSAIDS (used to relieve pain/reduce inflammation). Medication assessment of the potential for medication diversion and interventions to prevent diversion. n/a (not applicable).<br><br>R2's MAR's dated August 2022 and September 2022, indicated staff were administering one medication used to treat gout, four supplements, one used to treat hypothyroidism, one used for sleep, four used for constipation, one used for depression, one used for pain, one used to strengthen bones, three used for dry eyes, one used for restlessness and one used for sore throat. The MAR lacked addressing side effects, contraindications and necessary interventions, and adverse reactions and necessary interventions and indications for some of the medications as indicated on R2's medication assessment dated August 9, 2022.<br><br>R2's MAR's dated August 2022 and September 2022, indicated "okay to crush" for duloxetine (used for depression); however, according to the website medlineplus.gov directed "swallow the delayed-release capsules whole; do not split, chew, or crush them. Do not open the delayed-release capsules and mix the contents with liquids or sprinkle the contents on food."<br><br>R2's prescriber orders dated June 10, 2022, included the direction of take with eight ounces of | 01750 | | |

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| 01750 | Continued From page 122<br>water, on an empty stomach, remain upright 30 minutes for alendronate medication. The MAR lacked the direction for the alendronate medication as per prescriber orders. R2's MAR lacked direction for administration of alendronate.<br><br>R2's MAR also lacked parameters for hours apart for Systane eye drops (one drop both eyes four times daily as needed (PRN) for dry eyes), parameters for the amount to give for Meta powder (mix 1-2 rounded tablespoons in beverage and take once daily) and parameters for which PRN eye drop medication (Systane or artificial tears) to give first.<br><br>On September 12, 2022, at 10:13 a.m. RN-B verified R2's record lacked the above content.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01750 | | |
| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. | 01760 | | |

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| 01760 | Continued From page 123<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medication was administered as prescribed and direction for administration of medication was transcribed as prescribed for two of two residents (R2, R1). In addition, the licensee failed to follow up on as needed (PRN) medication effectiveness for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>R2<br>ADMINISTRATION OF MEDICATION<br>The licensee failed to ensure administration of the prescribed dose of Metamucil (used for constipation).<br><br>R2's prescriber orders dated June 10, 2022, included psyllium seed, sugar (fiber therapy, psyl, seed-sugar) take 1/2 teaspoon daily of fiber orange (helps keep bowel healthy). R2's medication administration record (MAR) dated September 2022, identified "SM Fiber ORG 48 doses 19 oz. [ounces] dissolve 1/2 teaspoonful in 8 oz. of water and take by mouth daily".<br><br>On September 7, 2022, at 8:13 a.m. unlicensed | 01760 | | |

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| 01760 | Continued From page 124 | 01760 | | |

personnel (ULP)-E was observed obtain Metamucil powder with label directions of take 1-2 rounded tablespoon in beverage every day. ULP-E obtained a plastic spoon (teaspoon size) and placed Metamucil powder onto one half of the plastic spoon. At the time ULP-E stated R2 was to receive 1/2 teaspoon and filled the spoon halfway was 1/2 teaspoon. ULP-E was observed to mix the powder in water and gave R2 the mixture to drink while taking oral medications. ULP-E walked out of R2's room with some of the mixture remaining in the cup. ULP-E failed to administer the right medication (Fiber orange), failed to measure the amount of Metamucil powder to ensure 1/2 teaspoon was given and failed to ensure R2 drank all of the medication.

R2's MAR dated September 2022, identified ULP-E signed for administration of Fiber orange on September 7, 2022, for the scheduled time of 9:00 a.m. The MAR indicated the Metamucil powder 1-2 tablespoons was to be administered once daily for the scheduled time of 8:00 p.m.

On September 8. 2022, at 2:27 p.m. registered nurse (RN)-B stated the Metamucil should be measured and all of the medication should be given.

The licensee's Approved Steps of Medication Pass Policy and Procedure Med Pass dated June 2020, indicated remain with the resident and observe the resident swallowing each medication, ensuring each pill is swallowed.

TRANSCRIPTION OF ORDERS
The licensee failed to ensure transcription of direction for administration of alendronate medication (used for bone strength).

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01760 | Continued From page 125<br><br>R2's prescriber orders dated June 10, 2022, included the direction of take with eight ounces of water, on an empty stomach, remain upright 30 minutes for alendronate medication. R2's MAR dated September 2022, lacked the direction for the alendronate medication as per prescriber orders.<br><br>On September 12, 2022, at 10:13 a.m. RN-B stated the direction for the alendronate medication should be on the MAR as per prescriber orders.<br><br>R1<br>R1's physician order from June 7, 2022, indicated, "For sudden nose bleed, apply several sprays of oxymetazoline (Afrin) nasal spray to both nostrils regardless of side of nose bleed."<br><br>R1's MAR's dated August 2022, and September 2022, indicated the following:<br>12 hour nasal spray (Afrin 0.05%), administer several sprays into both nostrils AS NEEDED for nose bleed. August 2022, and September 2022 MARS indicated an 8:00 a.m. daily scheduled time for this medication with various ULP initials indicating staff administered the nasal spray daily.<br><br>The licensee failed to follow the physician's order for oxymetazoline (Afrin) nasal spray as written and was administering the nasal spray scheduled daily when it was ordered to be given as needed in response to a nosebleed.<br><br>TRANSCRIPTION OF MEDICATIONS FOLLOW UP<br><br>R1's August 2022, MAR review, in section labeled "PRN Medications Log" indicated that on August | 01760 | | |

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| 01760 | Continued From page 126<br>19, 2022, at 2:38 a.m. and 9:02 a.m. staff administered acetaminophen 500 milligrams (mg) with a note that indicated "for pain in left foot and legs." There was no further documentation as to the effectiveness of the acetaminophen given for the pain.<br><br>The MAR lacked the required 30 minute follow up for effectiveness with medications given on an as needed basis.<br><br>On September 8, 2022 at 10:22 a.m. RN-C stated that the (nasal spray) order was confusing and was not sure why the Afrin nasal spray was scheduled when it read as needed. RN-C stated she would reach out to the nurse practioner (NP) for clarification and update the order. RN-C stated, "this is really confusing as to why we would schedule this (Afrin) nasal spray when we are already giving another nasal spray on a scheduled basis and even at the same time in the morning."<br><br>On September 12, 2022, at 12:00 p.m. RN-B stated that the expectation is for staff to check back with the resident after about a half hour for effectiveness of any as needed medication. RN-B stated that the eMAR has a built-in triggered mechanism within the eMAR to remind staff to check with resident and then provide follow up documentation. RN-B was unable to find any documented follow-up with these occurrences.<br><br>The licensee's "PRN use" policy revised March 9, 2011, indicated that after a half hour of medication being administered, the Med Passer documents on the back side of the PRN MAR the effect of the medication and initials the effect.<br><br>No further information was provided. | 01760 | | |

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| 01760 | Continued From page 127<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be | 01790 | | |

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| 01790 | Continued From page 128<br>labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations for preparing medications for resident unplanned times away were completed as required for one of one unlicensed personnel (ULP-E) with records reviewed.<br><br>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 | 01790 | | |

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| 01790 | Continued From page 129<br>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).<br><br>The findings include:<br><br>ULP-E had a hire date of May 11, 2022.<br><br>On September 7, 2022, at 8:13 a.m. ULP-E was observed to administer medications to R2.<br><br>ULP-E's record lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away.<br><br>On September 8, 2022, at 2:31 p.m. RN-B verified ULP were able to send medications with residents when they leave the facility. RN-B confirmed ULP-E lacked training and competency for the above.<br><br>On September 12, 2022, at 9:30 a.m. RN-B stated, the procedure for ULP to send medications with residents was "not in the competency training".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01820 SS=D | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed | 01820 | | |

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| 01820 | Continued From page 130<br>medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure prescriber's orders for medications for one of two residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2<br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed administer medications to R2.<br><br>R2's Medication Administration Record (MAR) dated September 2022, included the following:<br>-Metamucil powder mix 1-2 rounded tablespoons in beverage and take by mouth once daily to help promote bowels<br>-Systane complete eye drops one drop both eyes four times daily to both eyes as needed for dry eyes<br>-artificial tears (Visine tears) install one drop into each eye every two hours as needed for dry eyes<br><br>R2's prescriber's orders dated June 10, 2022, | 01820 | | |

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| 01820 | Continued From page 131<br>lacked orders for the above medications.<br><br>On September 12, 2022, at 10:13 a.m. registered nurse (RN)-B stated R2's primary physician would need to be contacted for clarification of orders.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the company required a prescription for all medication and treatment services team members manage for the residents. The RN was responsible for ensuring current prescriptions from authorized prescriber for medications and treatments and therapies administered by the team members and were kept in the resident record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions in one of one medication refrigerator.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01880 | | |

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| 01880 | Continued From page 132<br>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).<br><br>The findings include:<br><br>The licensee failed to monitor the temperature of a medication refrigerator to ensure medications were stored according to manufacturer's instructions.<br><br>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.<br><br>The refrigerator contained one or more of the following medications:<br>-glargine (Lantus) insulin pens (used for diabetes/blood sugar control)<br>-aspart (Novolog) insulin pens (used for diabetes/blood sugar control)<br>-Tresiba insulin pens (used for diabetes/blood sugar control)<br><br>Manufacturer's instructions for Lantus SoloStar insulin pens dated March 2020, indicated before opening store Lantus in the refrigerator 36 to 46 degrees F.<br><br>The manufacturer's instructions provided by the licensee for aspart dated revised November | 01880 | | |

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| 01880 | Continued From page 133<br>2019, indicated to store unused aspart pens in the refrigerator at 36 to 46 degrees F.<br><br>The manufacturer's instructions provided by the licensee for Tresiba revised November 2019, indicated store unused Tresiba pens in the refrigerator at 36 to 46 degrees F.<br><br>On September 8, 2022, at 9:50 a.m. registered nurse (RN)-B stated the licensee had "no temperature log" for the monitoring the temperature of the licensee's medication refrigerator.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01940 SS=E | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; | 01940 | | |

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| 01940 | Continued From page 134<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure an individualized treatment or therapy management record to include all required content for two of two residents (R2, R1).<br><br>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).<br><br>The findings include:<br><br>R2<br>R2's record lacked an individualized treatment or therapy record to include all content as required for treatment services of C-collar (neck brace), toe guards, ensure (supplement) and mechanical | 01940 | | |

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| 01940 | Continued From page 135<br>soft diet.<br><br>R2's diagnoses included dementia and repeated falls.<br><br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated resident required total assistance with dressing and undressing. C-collar used due to fracture. Attempts to take off C-collar. Skin care treatment instructions indicated R2 was at risk for skin breakdown due to C-collar. Daily skin check due to C-collar use. May 27, 2022, resident noted to have an old healing blister on top of right big toe. "Area will be observed daily and bandaid will be applied for protection. Toe guard to right toe will be held due to area until healed." The service plan/assessment indicated for the service of eating assistance, resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure and mechanical soft diet.<br><br>R2's Task Administration Record dated September 2022, indicated the same.<br><br>R2's observation notes indicated the following:<br>-dated April 25, 2022, resident is now on a mechanical soft diet, all foods should be soft. A mechanical soft diet guide is hanging in the kitchen for staff education.<br>-dated May 26, 2022, when putting on toe guard, I noticed a cut on big toe.<br>-dated June 28, 2022, family did bring Ensure bottles for resident. Will request for this to be given one time daily. Awaiting doctor orders.<br><br>On September 7, 2022, at 8:13 a.m. unlicensed | 01940 | | |

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| 01940 | Continued From page 136 | 01940 | | |

personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. The skin on R2's right great toe was intact (no blister was observed).

On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m. ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."

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 physician.
-prescriber 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.

R2's record lacked documented evidence of a prescriber's order for the C-collar, toe guards, ensure and mechanical soft diet.

R2's service pan lacked a written statement of the treatment or therapy services that would be provided to the resident (C-collar, toe guards, ensure, mechanical soft diet) and lacked a current individualized treatment and therapy management record for the treatment service of toe guards for the following:
-a statement of the type of services that will be provided;
-documentation of specific resident instructions

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| 01940 | Continued From page 137 | 01940 | | |

relating to the treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.

On September 7, 2022, at 10:27 a.m. registered nurse (RN)-B stated regarding if R2's record included a current individualized treatment and therapy management record for the treatment service of toe guards, "No, I don't think so."

On September 12, 2022, at 9:12 a.m. RN-C verified there was no prescriber's order for toe guards. 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." RN-B verified R2's record lacked an individualized treatment and therapy management record for the treatment services of toe guards, ensure and mechanical soft diet. RN-B stated, "I can't find an order for it [Ensure]. Family brought it up and asked us to give it for weight loss". RN-B stated R2 was to receive a mechanical soft diet per orders. RN-B verified R2's record lacked specific instructions for the treatment services of toe guards, ensure and mechanical soft diet.

R1
R1's diagnoses included type two diabetes (a

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01940 | Continued From page 138 | 01940 | | |

condition where the pancreas does not produce enough insulin to manage blood sugars), heart failure and intellectual disability.

R1's Treatment Plan integrated into R1's 90-day assessment dated August 16, 2022, indicated R1 received treatment services which included blood sugar checks. R1's Assessment/Treatment plan dated August 16, 2022, in section "Wellness Monitoring/Treatments" indicated "Is on scheduled insulin and blood sugar checks four times daily."

On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to check R1's blood sugar.

R1's Medication Administration Record (MAR) dated August and September 2022, indicated "blood glucose check (use to test blood sugar) up to 8 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 times per day."

R1's records lacked a prescriber's orders for blood sugar checks but, included provider orders for supplies of lancets and alcohol pads (used to check blood sugar) for up to eight (8) times daily.

R1's Treatment Plan lacked the treatment service of PRN blood sugar checks.

On September 9, 2022 at approximately 10:22 a.m. registered nurse (RN)-C verified R1's Treatment plan lacked revision for providing the additional as needed blood sugar testing.

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| 01940 | Continued From page 139<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the RN would develop an individualized treatment plan for each resident and would develop specific procedures for treatment services team members would provide.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01940 | | |
| 01950 SS=D | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by: | 01950 | | |

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| 01950 | Continued From page 140<br><br>Based on observation, interview and record review, the licensee failed to ensure an the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for one of two residents (R2) receiving treatments and had instructed the unlicensed personnel in the proper methods with respect to each resident and two of two unlicensed personnel (ULP-E, ULP-F) has demonstrated the ability to competently follow the procedures.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's diagnoses included dementia and repeated falls.<br><br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated resident required total assistance with dressing and undressing. C-collar (neck brace) used due to fracture. Attempts to take off C-collar. Skin care treatment instructions indicated R2 was at risk for skin breakdown due to C-collar. Daily skin check due to C-collar use. May 27, 2022, resident noted to have an old healing blister on top of right big toe. "Area will be observed daily and bandaid will be applied for protection. Toe guard to right toe will be held due to area until healed." The service plan/assessment indicated for the service | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01950 | Continued From page 141 | 01950 | | |

of eating assistance resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure (supplement) and and mechanical soft diet.

R2's Task Administration Record dated September 2022, indicated the same.

R2's observation notes indicated the following:
-dated April 25, 2022, resident is now on a mechanical soft diet, all foods should be soft. A mechanical soft diet guide is hanging in the kitchen for staff education.
-dated May 26, 2022, when putting on toe guard, I noticed a cut on big toe.
-dated June 28, 2022, family did bring Ensure bottles for resident. Will request for this to be given one time daily. Awaiting doctor orders.

On September 7, 2022, at 8:13 a.m. ULP-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. The skin on R2's right great toe was intact (no blister was observed).

On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m., ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."

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

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| 01950 | Continued From page 142 | 01950 | | |

summary was not signed by a physician.
-prescriber 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.

R2's record lacked documented evidence of a prescriber's order for the C-collar, toe guards, ensure and mechanical soft diet.

R2's record lacked documented specific instructions for the delegated treatment services of C-collar (neck brace), toe guards, ensure (supplement) and mechanical soft diet.

ULP TRAINING AND DEMONSTRATED COMPETENCY
ULP-E had a hire date of May 11, 2022.

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

ULP-E and ULP-F's record lacked training and demonstrated competency for providing the treatment services of R2's C-collar and toe guards.

On September 8, 2022, at 10:42 a.m. RN-B verified ULP-E and ULP-F lacked training and demonstrated competency for providing the treatment services of R2's C-collar and toe guards.

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." RN-B stated, "I can't find an order for it [Ensure]. Family brought it up and asked us to give it for weight

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| 01950 | Continued From page 143<br>loss". RN-B stated R2 was to receive a mechanical soft diet per orders. RN-B verified R2's record lacked specific instructions for the treatment services of C-collar, toe guards, ensure and mechanical soft diet.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the RN would develop an individualized treatment plan for each resident and would develop specific procedures for treatment services team members would provide. The RN would ensure unlicensed personnel were trained, competent, and orientated to the resident whenever unlicensed personnel were to perform treatment management services for the resident. A RN may delegate nursing services to unlicensed team members only after determining that the unlicensed person was trained and competent and had been instructed in the proper methods to perform the procedures with respect to the specific resident. Including written instructions for performing the procedure for the resident in the resident record. Treatments were documented on the Medication Administration Record (MAR) in electronic charting. The treatment protocol would include specific details on how the treatment was to be performed, the frequency of the treatment, and any specific instructions related to the treatment.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01950 | | |
| 01960 SS=D | 144G.72 Subd. 5 Documentation of administration of treatments | 01960 | | |

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| 01960 | Continued From page 144<br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of two residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>The licensee failed to ensure accurate documentation for C-collar (neck brace) (refusing) and failed to document for providing the treatment service of toe guards and Ensure (supplement).<br><br>R2's diagnoses included dementia and repeated falls. | 01960 | | |

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| 01960 | Continued From page 145<br><br>On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. The skin on R2's right great toe was intact (no blister was observed).<br><br>On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m. ULP-D stated she was not sure if R2 was to be wearing C-collar (neck brace) or not.<br><br>R2's Service Plan integrated into R2's 90-day assessment dated August 9, 2022, indicated resident required total assistance with dressing and undressing. C-collar used due to fracture. Attempts to take off C-collar. Skin care treatment instructions indicated R2 was at risk for skin breakdown due to C-collar. Daily skin checks due to C-collar use. May 27, 2022, resident noted to have an old healing blister on top of right big toe. "Area will be observed daily and bandaid will be applied for protection. Toe guard to right toe will be held due to area until healed." R2's service plan lacked the treatment services of toe guards to right and left great toes and Ensure.<br><br>R2's Task Administration Record dated September 2022, indicated C-collar: staff are to ensure that the resident has C-collar on at all times. Please document here if resident removes C-collar. Has foam collar to change into when taking a shower.<br><br>R2's record included the following:<br>-prescriber 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 | 01960 | | |

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| 01960 | Continued From page 146<br>prescriber's order regarding if the collar was discontinued or not.<br><br>R2's record lacked documented evidence of a prescriber's order for the C-collar, toe guards, ensure and mechanical soft diet.<br><br>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.<br><br>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.<br><br>The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated treatments were documented on the Medication Administration Record (MAR) in electronic charting. The treatment protocol would include specific details on how the treatment was to be performed, the frequency of the treatment, and any specific instructions related to the treatment.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01960 | | |
| 01970 SS=E | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized | 01970 | | |

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prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review the licensee failed to ensure a prescriber's order for treatment or therapy 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:

R2
R2's diagnoses included dementia and repeated falls.

On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medications to R2 and applied toe guards to R2's right and left great toes. The skin on R2's right great toe was intact (no blister was observed).

On September 8, 2022, at 9:28 a.m. ULP-D stated the staff were monitoring R2's intake and

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R2 was given "Ensure supplement. If not eating, we push Ensure." At 9:32 a.m. ULP-D stated she was not sure if R2 was to be wearing C-collar or not. ULP-D stated R2 was on a "mechanical soft texture" diet and "meat was shredded, swallows better."

R2's Service Plan integrated into R2's 90 day assessment dated August 9, 2022, indicated resident required total assistance with dressing and undressing. C-collar used due to fracture. Attempts to take off C-collar. Skin care treatment instructions indicated R2 was at risk for skin breakdown due to C-collar. Daily skin check due to C-collar use. May 27, 2022, resident noted to have an old healing blister on top of right big toe. "Area will be observed daily and bandaid will be applied for protection. Toe guard to right toe will be held due to area until healed." The service plan/assessment indicated for the service of eating assistance resident is in aspiration precaution and mechanical soft diet. Resident is to remain upright 30 minutes after eating. R2's service plan lacked the treatment services of toe guards to right and left great toes, Ensure and mechanical soft diet.

R2's Task Administration Record dated September 2022, indicated the same as above and for C-collar staff are to ensure that the resident has C-collar on at all times. Please document here if resident removes C-collar. Has foam collar to change into when taking a shower.

R2's observation notes indicated the following:
-dated April 25, 2022, resident is now on a mechanical soft diet, all foods should be soft. A mechanical soft diet guide is hanging in the kitchen for staff education.
-dated May 26, 2022, when putting on toe guard, I

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noticed a cut on big toe.
-dated June 28, 2022, family did bring Ensure bottles for resident. Will request for this to be given one time daily. 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 physician.
-prescriber 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.

R2's record lacked documented evidence of a prescriber's order for the C-collar, toe guards, ensure and mechanical soft diet.

On September 12, 2022, at 9:12 a.m. registered nurse (RN)-C verified there was no prescriber's order for toe guards. 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." RN-B stated, "I can't find an order for it [Ensure]. Family brought it up and asked us to give it for weight loss". RN-B stated R2 was to receive a mechanical soft diet per orders.

R1
R1's diagnoses include type 2 diabetes (a condition where the pancreas does not produce enough insulin to manage blood sugar), heart failure and intellectual disability.

R1's Treatment plan integrated into R1's 90-day assessment dated August 16, 2022, indicated R1

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| 01970 | Continued From page 150 | 01970 | | |

received treatment services which included blood sugar checks. R1's Assessment/Treatment plan dated August 16, 2022, in section "Wellness Monitoring/Treatments" indicated "Is on scheduled insulin and blood sugar checks four (4) times daily."

On September 7, 2022, at approximately 11:00 a.m. ULP-E was observed to check R1's blood sugar.

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."

R1's records lacked a prescriber's orders for blood sugar checks but, included provider orders for supplies of lancets and alcohol pads (used to check blood sugar) for up to eight (8) times daily.

On September 9, 2022, at approximately 10:22 a.m. registered nurse (RN)-C verified R1's record lacked treatment orders to include blood sugar checks.

The licensee's Minnesota Delegation of Medication Management and Treatment Services Policy dated June 2020, indicated the company required a prescription for all medication and treatment services team members manage for the residents. The RN was responsible for ensuring current prescriptions from authorized prescriber for medications and treatments and therapies administered by the team members and

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| 01970 | Continued From page 151<br>were kept in the resident record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01970 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to | 02110 | | |

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and from outside medical appointments; and
(10) safekeeping of residents' possessions.
(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care 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 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 was licensed as an Assisted Living with Dementia Care facility on August 1, 2022.

The licensee lacked the following policies and procedures related to dementia care:
- philosophy of how services are to be provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy will be implemented;
- evaluation of behavioral symptoms and design

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| 02110 | Continued From page 153<br>of supports for intervention plans. Lacks content that includes nonpharmacological practices that are person-centered and evidence-informed;<br>- medication management, including an assessment of residents for the use and effects of medications- lacks content that includes psychotropic medications;<br>- staff training specific to dementia care;<br>- description of life enrichment programs and how activities are implemented;<br>- description of family support programs and efforts to keep family engaged;<br>- limiting the use of public address and intercom systems for emergencies and evacuation drills;<br>- transportation coordination and assistance to and from outside medical appointments; and<br>- safekeeping of residents' possessions<br><br>The licensee failed to provide policies and procedures to residents and the residents' legal and designated representative at the time of move in.<br><br>On September 12, 2022, at approximately 9:30 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B stated they were not aware of dementia specific policies. LALD-A stated the policies were difficult to find within their company electronic system. With review of missing policies or missing content, LALD-A and RN-B stated they would have to inquire further. LALD-A stated that some content of some of the policies were included in the contract and/or a handbook that is given to residents and their representative at time of admission.<br><br>No further information was provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02110 | | |

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| 02260 SS=C | 144G.90 Subd. 3 Notice of dementia training<br><br>An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to include a description of the training program for dementia care in written or electronic form to residents, families, or other persons who request it, with records reviewed.<br><br>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).<br><br>The findings include:<br><br>The licensee's Residence and Services Agreement included "Dementia Specific Training" which described the categories of employees trained, the frequency of training, and the basic topics covered and indicated "Consumer Information. The community will provide to consumers in written or electronic form a description of its training program, the categories of staff trained, the frequency of training and the | 02260 | | |

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| 02260 | Continued From page 155<br>basic topics covered." The information lacked a description of the training program (how the training was provided).<br><br>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."<br><br>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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02260 | | |
| 02310 SS=G | 144G.91 Subd. 4 Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards | 02310 | | |

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with bedrails/side rails for one of one resident (R2) with record reviewed. This resulted in an immediate correction order on September 7, 2022, at 1:15 p.m.

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

The findings include:

R2's Resident Information sheet dated September 7, 2022, included diagnosis of unspecified dementia without behavioral disturbance.

R2's record identified the following:
- Restrictive Procedure Assessment Assist device dated August 12, 2022, indicated type of assistive device was quarter side rail/bed rail or repositioning bar, the circumstance surrounding the assistive device was being considered for preceding events and conditions that nay have triggered the symptom: "numerous falls out of bed," underlying cause of the symptom was "dementia" and indicated "no risk with positioning bar, benefit is that resident will be able to position herself correctly while in bed."
-Negotiated Risk Agreement dated and signed by R2's responsible party on February 9, 2022, indicated R2 would like to use the grab bar to turn over on side during sleeping hours for positioning, R2's doctor provided an order for the repositioning bar and R2's responsible party was

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aware of the purpose of the bar and had been informed of the potential risks involved with its use, including the possibility of becoming entangled between the bars.

On September 7, 2022, at 8:13 a.m. unlicensed personnel (ULP)-E was observed to administer medication to R2 in R2 room. R2's bed was observed to have a grab bar (physical assist device) in place on the upper right side of the bed.

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."

R2's record lacked documented evidence of manufacturer instructions for the grab bar device, and documented evidence if there was a recall for the device or not.

On September 7, 2022, at 12:08 p.m. the surveyor requested RN-B to provide the manufacturer instructions and whether the grab bar device was recalled. RN-B stated she would check to see if there was a recall.

On September 7, 2022, at 12:30 p.m. RN-C provided the surveyor with the manufacturer

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| 02310 | Continued From page 158<br>instructions for the grab bar device. RN-C stated, "I called the company" (for grab bar device), "they are not aware of recall, but the company has been sold a couple of times."<br><br>The Consumer Product Safety Commission (CPSC) Urges Consumers to Immediately Stop Use of Mobility Transfer Systems Adult Portable Bed Rails Due to Entrapment and Asphyxia Hazard; Three Deaths Reported release date June 2, 2022, for Freedom Grip Model 501. CPSC's warning applies to 10 models of bed rails. The bed rails were manufactured and sold by Mobility Transfer Systems Inc. from 1992 to 2021, and by Metal Tubing USA Inc. in 2021 and 2022.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE<br><br>On September 8, 2022, at 2:17 p.m. the immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 02310 | | |
| 02480 SS=D | 144G.91 Subd. 20 Grievances and inquiries<br><br>Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. | 02480 | | |

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| 02480 | Continued From page 159<br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to respond to grievances of one of one resident (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On September 6, 2022, at approximately 10:27 a.m. the surveyor requested the licensee's grievances.<br><br>The licensees' grievances included a handwritten note dated May 1, 2022, and an undated handwritten note for concerns regarding R2.<br><br>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.<br><br>The undated note indicated the family member of R2 called to complain about medical | 02480 | | |

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transportation, R2 having no glasses, hearing aid or walker, the TV shows R2 was watching and clothing concern for clothing R2 was supposed to be in on Halloween.

On September 8, 2022, at 12:54 p.m. registered nurse (RN)-B provided an email sent to R2's guardian on May 3, 2022, from licensed practical nurse (LPN)-G indicating after speaking with the hospital staff (nurse and social worker) it has been determined R2 needs one to one in order to continue to be safe. The facility does not have staffing to meet this need. My recommendation, for safety would be to keep her where she can receive one to one care or place her in a facility where she can receive one to one care. My concerns are she may fall again due to increased restlessness and us unable to adequately staff one to one care. As soon as she no longer requires one to one staffing, we would be happy to accept her back to our care.

R2`s record lacked evidence of responses to the grievances or attempts to resolve the grievances.

On September 8, 2022, at 1:17 p.m. RN-B stated she had no other information regarding the above grievances.

The licensee's Grievance and Complaint Process policy dated January 7, 2020, indicated any resident, guardian, agent or designated representative may file a grievance or complaint with our company. The director within 15 days of receipt of the grievance would inform the resident involved regarding the grievance, findings, and conclusion. After receipt of the grievance by the area director, a reply to the resident within 10 days from receipt of grievance would be completed. A written summary of the grievance,

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| 02480 | Continued From page 161<br>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.<br><br>No other information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 02480 | | |
| 03000 SS=E | 626.557 Subd. 3 Timing of report<br><br>(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:<br>(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<br>(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).<br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has | 03000 | | |

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been made to the common entry point.
(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.
(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse and failed to complete a thorough investigation for occurrences of suspected abuse for three of three residents (R3, R2, R4).

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more

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than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R3
The licensee lacked immediate report to MAARC of resident to resident altercations (physical and sexual) and lacked evidence of documentation of a thorough investigation of staff and resident interviews related to the altercations.

R3's diagnoses included dementia (memory loss).

R3's Resident Event Reports included the following:
-dated August 8, 2021, indicated resident to resident altercation. Resident #1 (R2) threw her walker at resident #12 (R3). Other outcome and follow up actions: Resident shows no injury from incident. When nurse asked him about it, R3 stated "it did not hit me".

-dated August 22, 2021, indicated resident to resident altercation. Resident #16 and resident #12 [R3] were in the back living room. Resident #16 asked R3 if he was sleeping with those women (referring to staff). Resident #16 was getting aggressive and agitated. Resident #16 started hitting R3 with her cane. Other outcome and follow up actions: per staff interviews from incident the two residents were separated. Resident shows no injury from being hit with the cane. Staff would separate the residents when staff noticed resident #16 becomes agitated.

-dated August 24, 2021, indicated resident to resident altercation. Staff entered resident #16's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30630 | A. BUILDING: _____ 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 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 03000 | Continued From page 164 | 03000 | | |

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 (POA) was contacted and agreed relationship was ok as long as both resident parties agree the relationship was ok. Staff would intervene if needed due to all parties not agreeing yet to relationship between the two residents.

-dated September 10, 2021, indicated resident to resident altercation Resident #12 [R3] was sitting peacefully in the front when resident #16 started yelling at him and tried to lunge at him. This writer stepped in between and called for help. Resident were able to be redirected and altercation 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 become agitated with resident. Staff continue to watch for behaviors and intervene and separate the resident's if needed.

R3's record included the following MAARC reports:
-date and time submitted Wed. September 1, 2021, at 1:13 p.m. indicated on August 30, 2021, at 5:00 p.m. R3 and resident #16 have engaged in a sexual relationship with one another. Staff have observed a sexual act between the two residents. Both residents have consented to the relationship. Both residents' POAs are aware of the relationship and have agreed they may engage in the relationship.

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|---|---|---|---|---|
| 03000 | Continued From page 165<br><br>On September 8, 2022, at 12:56 p.m. registered nurse (RN)-B stated she had no other MAARC reports for the above resident to resident altercations. RN-B stated both residents (R3 and resident #16) had a dementia diagnosis. RN-B was unable to identify who resident #16 was, and she would have to look for more information regarding the above Resident Event Reports. However, no further information was provided.<br><br>R2<br>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.<br><br>R2's diagnoses included dementia.<br><br>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. | 03000 | | |

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|---|---|---|---|---|
| 03000 | Continued From page 166<br><br>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.<br><br>R4<br>The licensee lacked immediate report to MAARC of injury of unknown origin and lacked evidence of documentation of a thorough investigation of staff, resident and other resident interviews related to the injury of unknown origin to determine if abuse occurred.<br><br>R4's diagnoses included dementia.<br><br>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.<br><br>On September 8, 2022, at 10:46 a.m. RN-B stated she was "not sure why" the R4's injury was | 03000 | | |

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| 03000 | Continued From page 167<br>reported late to MAARC. RN-B stated that's "all I have," regarding documented information of R4's reported injury above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 03000 | | |
| 03090 SS=C | 144.6502, Subd. 8 Notice to Visitors<br><br>Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br><br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee.<br><br>This practice resulted in a level one violation (a violation that has not 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 | 03090 | | |

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| 03090 | Continued From page 168<br>the residents).<br><br>The findings include:<br><br>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.<br><br>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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 03090 | | |

DEPARTMENT OF HEALTH

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

# Food and Beverage Establishment Inspection Report



**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

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 Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us