Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

October 23, 2024

Licensee
Providence Villa LLC
200 Minnesota Avenue East
Sebeka, MN 56477

RE: License Number 418162
Health Facility Identification Number (HFID) 34011
Project Number(s) SL34011015

Dear Licensee:

On September 25, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 3, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective October 23, 2024.

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-4181 Fax: 651-215-9697

JMD

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

August 6, 2024

Licensee
Providence Villa LLC
200 Minnesota Avenue East
Sebeka, MN 56477

RE: Conditional License Number 414206
Health Facility Identification Number (HFID) 34011
Project Number(s) SL34011015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 3, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **November 4, 2024.**

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

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

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

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

Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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

The correction order documentation should include the following:

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

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

CONDITIONAL LICENSE ISSUED:
MDH will issue Providence Villa 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 survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey,

MDH will determine if Providence Villa LLC is in substantial compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Providence Villa LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Providence Villa LLC must provide the Department:

   i. A list of the names and birthdates of any individuals Providence Villa 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:** Providence Villa LLC will contract with an RN to provide consultation concerning all resident(s) to whom Providence Villa LLC provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Providence Villa 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</u>. The RN must not have any affiliation with Providence Villa LLC and MDH must review the RN's credentials and approve the selection. Providence Villa LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Providence Villa LLC in an effort to help Providence Villa 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 substantial compliance and/or concerns about observations. Providence Villa 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 substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Providence Villa LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Surveyor Supervisor, State Evaluation Team, Health Regulation Division, at Jessie.Chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office)

with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Providence Villa LLC to correct the violations cited during the survey as well as to determine the overall practice of Providence Villa 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 survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Providence Villa 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 substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Providence Villa LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Providence Villa LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Providence Villa LLC's assisted living facility license, and Providence Villa LLC will correct any outstanding violations identified during the survey. If Providence Villa LLC is not in substantial compliance on the follow-up

survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Providence Villa LLC. Please contact Jessie Chenze at 218-332-5175 **on or before Friday, August 16, 2024**, to schedule the conference call.

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34011	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE VILLA LLC	200 MINNESOTA AVENUE EAST SEBEKA, MN 56477

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34011015 On July 1, 2024, through, July 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents receiving services under the provider's Assisted Living Facility license. Immediate correction orders were identified on July 2, 2024, issued for SL34011015, tag identification 1290 and 2310. On July 3, 2024, the immediacy of correction order 1290 was removed, however, noncompliance remained at a scope and level of I. Immediacy of correction order 2310 was not removed prior to survey exit on July 3, 2024, and	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 noncompliance remains at a scope and level of I.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter	0 250		

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0 250	Continued From page 2 or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 250		

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0 250	Continued From page 3 During the entrance conference on July 1, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final)	0 250		

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0 250	Continued From page 4 (opens in a new window), 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 f a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner (O-A) on September 25, 2023. The licensee had an assisted living license, effective October 1, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or	0 250		

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0 250	Continued From page 5 appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers; - supervision of unlicensed personnel; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; and - medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals. As a result of the survey, the following correction orders were issued, 0480, 0510, 0550, 0630, 0640, 0650, 0660, 0680, 0690, 0730, 0810, 0900, 1060, 1290, 1370, 1380, 1440, 1470, 1500, 1530, 1550, 1560, 1620, 1730, 1750, 1760, 1790, 1890, 1950, 2310, 3090 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	0 480		

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0 480	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 2, 2024 , for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Reference dates listed in FBEIR report.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the 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	0 510		

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0 510	Continued From page 7 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed during medication administration and by disinfecting shared equipment between resident use by one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 7:32 a.m., the surveyor observed ULP-C gather R3's nebulizer medication from the medication cart, enter R3's room, set up R3's nebulizer and hand R3's his nebulizer for administration. ULP-C exited R3's room and without performing hand hygiene, ULP-C proceeded to prepare and administer R6's scheduled morning medications. Without performing hand hygiene, ULP-C prepared and administered R8's morning medications. -At 7:49 a.m., ULP-C entered R3's room and prepared R3's second nebulizer treatment, ULP-C exited R3's room, and without performing hand hygiene, ULP-C entered the kitchen and removed pitchers of juice from the fridge and set up the morning beverage cart. ULP-C poured R3	0 510		

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PROVIDENCE VILLA LLC	200 MINNESOTA AVENUE EAST SEBEKA, MN 56477

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0 510	Continued From page 8 a glass of milk and delivered with silverware to R3. -At 7:53 a.m., ULP-C obtained R4's blood pressure with the shared automatic blood pressure machine. ULP-C placed the blood pressure machine on the medication cart without sanitizing after use and recorded R4's blood pressure of 158/89. ULP-C proceeded and set up and administer R4's morning medications. Without performing hand hygiene, ULP-C prepared and administered R8 and R10's morning medication then entered R3's room and turned off R3's nebulizer machine. ULP-C did not perform hand hygiene. -At 8:39 a.m., ULP-C obtained the automatic blood pressure cuff and pulse oximeter and entered R3's room. ULP-C checked R3's blood oxygen level with the use of the oximeter and blood pressure. ULP-C did not sanitize the shared equipment before or after resident use of perform handhygiene after resident contact. -At 8:48 a.m., ULP-C checked R7's blood pressure with the automatic blood pressure machine then placed the blood pressure machine on the counter at the nurses station. ULP-C did not disinfect the shared blood pressure machine before or after resident use or perform hand hygiene. On July 2, 2024, at 11:05 a.m., ULP-C stated she didn't realize she did not perform hand hygiene in between administering resident medications. ULP-C stated they had sanitizing wipes but not the right ones for disinfecting equipment. ULP-C stated she should have performed hand hygiene in between resident care and disinfected the blood pressure machine in between resident use with the disinfecting wipes. On July 3, 2024, at 4:23 a.m., during a telephone	0 510		

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0 510	Continued From page 9 interview, CNS-B stated staff should be performing hand hygiene before preparing medications and in between administering resident medications. CNS-B stated disinfecting wipes were available for staff to use to disinfect shared equipment. CNS-B stated the licensee had disinfecting disposable wipes; however, did not have medical grade disinfecting wipes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required	0 550		

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0 550	Continued From page 10 information related to the grievance procedure and contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: On July 1, 2024, at 12:20 p.m., during a facility tour with clinical nurse supervisor (CNS)-B, CNS-B confirmed the licensee's grievance procedure observed posted at the main entrance of the building; however, lacked the contact information of the Office of Ombudsman for Developmental Disabilities and the contact information to Minnesota Adult Reporting Center (MAARC). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 11 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 1, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease,	0 630		

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0 630	Continued From page 12 and chronic obstructive pulmonary disease. R2's Service Plan dated March 28, 2024, indicated R2 received assistance with dressing, bathing, blood glucose monitoring, medication management, housekeeping and laundry. On July 2, 2024, at 8:22 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled morning medications. R3 R3's diagnoses included malignant neoplasm of prostate (prostate cancer), chronic pain, chronic obstructive pulmonary disease (COPD), and diabetes type II. R3's Service Plan dated April 6, 2023, indicated R3 received assistance with medication management, skin care, ace wraps, housekeeping and laundry. On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. R2 and R3's Vulnerability, Safety and Risk assessments dated March 23, 2024, and April 11, 2024, respectively, lacked an individual assessment of the resident's susceptibility to abuse by other individuals. On July 3, 2024, at 9:08 a.m., CNS-B reviewed R2 and R3's Vulnerability, Safety and Risk assessments and stated the R2 and R3's assessments did not include a review of a resident's susceptibility to abuse by others and was unaware of the requirement.	0 630		

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0 630	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c 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: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 640		

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0 640	Continued From page 14 The findings include: On July 1, 2024, at 12:20 p.m., during a facility tour with clinical nurse supervisor (CNS)-B, the surveyor did not observe 911 emergency number posted in any common areas, or near phones at the assisted living. CNS-B stated she was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 15 required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: CNS-B CNS-B had a hire date of October 1, 2018, under the comprehensive home care license and began to provide assisted living services on August 1, 2021. CNS-B's employee record contained a RN Manager Annual Performance Review dated October 30, 2019. CNS-B's record lacked evidence an annual performance review had been completed since 2019. ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began to provide assisted living services on August 1, 2021.	0 650		

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0 650	Continued From page 16 On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. ULP-C 's employee record lacked evidence ULP-C had documentation of annual performance reviews that defined areas of improvement needed and training needs. In addition, ULP-C's employee record lacked documentation ULP-C had received the following competencies: -administering medications or treatments as required. On July 3, 2024, at 9:27 a.m., CNS-B stated she completed ULP-C's medication training and competency evaluations and was unable to find all ULP-C's competency evaluations. At 10:06 a.m., CNS-B stated licensed assisted living director (LALD)-A completed her annual performance reviews and CNS-B was unable to provide performance reviews after 2019. CNS-B confirmed ULP-C's employee record lacked evidence of annual performance reviews. On July 3, 2024, at 11:46 a.m., ULP-C stated she was trained, and competency tested by CNS-B. ULP-C stated she remembers CNS-B completing a checklist of tasks CNS-B observed ULP-C perform; however, was unable to recall each individual competency skills test. The licensee's undated Personnel Files/Employee Records policy indicated every employee by the licensee shall have a personnel file created upon hire and would and shall contain: -for ULPs, evidence of completed competency evaluations, conducted by an RN for delegated	0 650		

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0 650	Continued From page 17 nursing services or conducted by a therapist for delegated therapy services, indicating competency in the delegated areas; and -documentation of annual performance review, which identify areas of improvement and training recommendations. The licensee's Employee Evaluation policy dated September 22, 2018, indicated all staff of the licensee would be given and employee evaluation at least annually, if not more often by the employer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 18 by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 3, 2024, at 11:57 a.m., the surveyor reviewed the Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health) dated October 1, 2018, with clinical nurse supervisor (CNS)-B. CNS-B stated she was unable to find a more current facility TB risk assessment. CNS-B stated the facility TB Risk Assessment should be completed every two years while in a low-risk setting. The licensee's undated Tuberculosis and Staff Screening policy indicated the licensee shall complete a written community TB risk assessment and update the assessment data on an annual basis. The form used shall be the one developed by the Minnesota Department on Health. No further information was provided.	0 660		

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0 660	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post and develop a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to	0 680		

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0 680	Continued From page 20 ensure the licensee's missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 12:20 p.m., during a facility tour with clinical nurse supervisor (CNS)-B, the surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. CNS-B stated the licensee's EPP binder was located at the nurses station and was not aware the EPP needed to be in a prominent area of the facility. The licensee's undated Emergency Preparedness Manual did not include the following required information: -documentation the emergency plan was reviewed annually; -a hazard vulnerability assessment; -documentation the missing resident plan was reviewed quarterly; and -emergency prep testing requirements. On July 1, 2024, at 3:12 p.m., maintenance (M)-E stated the licensee's EPP was developed sometime in 2023, and did not have any documentation when the EP plan was developed or last reviewed. M-E stated the licensee had not participated in any annual full-scale exercise or	0 680		

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0 680	Continued From page 21 tabletop emergency exercises and documentation the licensee analyzed the facility's response. M-E verified the Hazard Vulnerable Analysis was not in the EP binder and stated it had been developed and may be in the computer. M-E stated he was unaware the missing resident policy was required to be reviewed quarterly. The licensee's Disaster Planning and Emergency Preparedness policy dated September 10, 2018, indicated the licensee would have a written plan of action to facilitate the management of clients care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. The licensee shall conduct a Hazard Vulnerability Analysis (HVA) to determine the probability of events, the risk of events, and the level of current preparedness by the provider. The licensee's undated Emergency Preparedness Program, indicated the plan was a living document that would be reviewed at least annually and updated as necessary based on "lessons learned" during exercise or real events; the evolution of new "best practices:; or changes to local, state, and federal regulatory requirements. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is	0 680		

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0 680	Continued From page 22 incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain records in resident records with current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry for one of one resident (R4). 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	0 690		

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0 690	Continued From page 23 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4's diagnosis included cerebral vascular accident (CVA/stroke). R4's Service Plan dated June 25, 2022, indicated R4 received assistance with bathing, dressing, toileting, transfers/mobility, housekeeping, laundry, and medication administration; however, lacked authentication of the date and name of the resident and/or resident's representative. R4's annual assessment dated June 24, 2024, lacked authentication of the name and title of the person who completed R4's assessment. On July 2, 2024, at 2:32 p.m., CNS-B stated she was unable to locate R4's signed Service Plan and confirmed she had not physically or electronically signed R4's annual assessment. The licensee's undated Service Plans policy indicated the service plan and any revisions must include a signature or other authentication by the licensee and by the tenant or the tenant's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 24 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

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0 730	Continued From page 25 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 diagnosed included Alzheimer's disease. R1 began receiving services on October 29, 2023, and was discharged March 30, 2024. R1's record lacked evidence a discharge summary had been completed. On July 1, 2024, at 2:08 p.m., clinical nurse supervisor (CNS)-B stated she had not completed a discharge summary for R1 and was aware of the requirement.	0 730		

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0 730	Continued From page 26 The licensee's Client Record-Outline policy undated, indicated client records must include a discharge summary, including service termination notice and related documentation when applicable. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 27 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 02, 2024, at 10:17 a.m., maintenance (M)-E provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee or resident actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or	0 810		

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0 810	Continued From page 28 similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan was general and referenced the RACE (rescue, alarm, confine, extinguish and evacuate) acronym. During interview, M-E verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (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. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (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. (d) A contract under this section is a consumer	0 900		

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0 900	Continued From page 29 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract, with the required content prior to providing assisted living services for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease, and chronic obstructive pulmonary disease. On July 2, 2024, at 8:22 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled morning medications.	0 900		

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0 900	Continued From page 30 R2's Progress Notes dated March 18, 2024, at 11:32 a.m., indicated R3's family made a deposit on R3's room. On March 23, 2024, at 10:00 a.m., R2 arrived at the facility escorted by family. R2's Service Plan dated March 28, 2024, indicated R2 received assistance with dressing, bathing, blood glucose monitoring, medication management, housekeeping and laundry. R2's March, April and May's 2024, Service Delivery Records indicated R2 received the following services from the licensee: housekeeping, laundry, medication administration, bathing, dressing, grooming, blood glucose monitoring, and wellness checks. R2's record indicated R2 was admitted on March 23, 2024, and R2's Assisted Living Contract was signed May 4, 2024, after R2 received assisted living services provided by the licensee. On July 3, 2024, at 9:10 a.m., clinical nurse supervisor (CNS)-B verified R2's Assisted Living Contract was signed after services were provided and stated she was unsure why R2's contract was not signed on admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of	01060		

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01060	Continued From page 31 another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R3) reviewed for a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R3's diagnoses included malignant neoplasm of prostate (prostate cancer), chronic obstructive pulmonary disease, diabetes type II, and chronic pain. R3's progress note dated April 21, 2024, indicated R3 was transferred to the hospital via ambulance. R3's progress note dated May 13, 2024, indicated R3 was discharged from the hospital and returned to the facility. R3's record lacked evidence a written notice was provided to R3 or R3's representative or notification was provided to the Office of Ombudsman for Long-Term Care for R3's hospitalization of four days or longer.	01060		

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01060	Continued From page 33 On July 2, 2024, at 1:01 p.m., clinical nurse supervisor (CNS)-B stated R3 went into the hospital on April 21, 2024, and returned to the facility May 13, 2024. CNS-B stated a written notice of emergency relocation was not provided to R3 or R3's representative and notification was not sent the Ombudsman informing of R3's hospitalization longer than four days. CNS-B stated she was aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees with	01290		

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01290	Continued From page 34 access to residents and resident records had a cleared background study completed via NetStudy 2.0 for 5 of 17 employees (unlicensed personnel (UPL-D, ULP-F, ULP-G, ULP-H), cook (C-I). This had the potential to affect all residents, employees, and visitors. 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). This resulted in an immediate correction order on July 2, 2024. The findings include: ULP-D ULP-D was hired on January 27, 2024, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 2, 2024, at 1:46 p.m., indicated a background study had not been submitted for ULP-D. ULP-F ULP-F was hired on May 4, 2023, to provide direct care services to residents of the facility. ULP-F's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 2, 2024, at 1:46 p.m., indicated a background study had not been submitted for ULP-F. ULP-G ULP-G was hired on September 23, 2023, to provide direct care services to residents of the facility. ULP-G's employee record lacked documentation of a cleared background study.	01290		

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01290	Continued From page 35 Review of NetStudy 2.0 on July 2, 2024, at 1:46 p.m., indicated a background study had not been submitted for ULP-G. ULP-H ULP-H was hired on May 23, 2024, to provide direct care services to residents of the facility. ULP-H's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 2, 2024, at 1:46 p.m., indicated a background study had not been submitted for ULP-H. C-I C-I was hired on March 8, 2024, to provide dining and food service to residents of the facility. C-I's employee record lacked documentation of a cleared background study. Review of NetStudy 2.0 on July 2, 2024, at 1:46 p.m., indicated a background study had not been submitted for C-I. On July 2, 2024, at 2:32 p.m., clinical nurse supervisor (CNS)-B stated she was unable to located any background study clearance letters in ULP-D, ULP-F, ULP-G, ULP-I or C-I's employee records. CNS-B stated the ULPs noted above provided independent direct resident contact during their shift and were not under direction supervision by another employee. The licensee's Background Checks policy, dated September 14, 2018, noted licensee would conduct a Minnesota Department of Human Services Background Study on all employees of the licensee who will have independent direct contact with residents of licensee. No employee may have independent direct contact with any residents until acceptable result of the background study have been received. The licensee will not employer individuals whose results of the background study indicate disqualification for the position ... 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate	01290		

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01290	Continued From page 36 more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to residents of licensee except under the direct supervision (eyesight) of another qualified person. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed on July 3, 2024, based on review by survey supervisor, however, noncompliance remains at a scope and level two, widespread (l).	01290		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 37 (10) preparation of modified diets as ordered by a licensed health professional; (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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP)-C, ULP-D). 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: ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1,	01370		

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01370	Continued From page 38 2021. On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. ULP-C's employee record lacked evidence ULP-C received the following require training and/or competencies: -standby assistance techniques and how to perform them; -medication, exercise, and treatments; -basic nutrition, meal preparation, food safety, and assistance with eating; and -preparation of modified diets as ordered by a licensed health professional. On July 3, 2024, at 11:46 a.m., ULP-C stated she was trained and competency tested by clinical nurse supervisor (CNS)-B. ULP-C stated she remembers CNS-B completing a check-list of tasks CNS-B observed ULP-C perform but was unable to recall each individual skill. ULP-D ULP-D had a hire date of January 27, 2024, to provide direct care services to the licensee's residents. ULP-D's employee record lacked evidence ULP-D received the following required training and/or competencies: -documentation requirements for all services provided; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting;	01370		

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01370	Continued From page 39 -medication, exercise and treatment reminders; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assisted devices. On July 3, 2024, at 9:27 a.m., CNS-B stated staff training materials were in paper form and CNS-B completed staff competency evaluations in person before ULPs were allowed to work with residents. CNS-B stated ULP-D was not trained on medication administration because ULP-D did not administer medication and assisted with resident cares, transfers, mobility, meals, compression stockings, and vital signs. CNS-B stated she completed ULP-D's competency evaluations; however, was unable to find ULP-D's training records. CNS-B stated she completed ULP-C's medication training and competency evaluations and was unable to find all of ULP-C's competency evaluations. The licensee's undated Training and Competency Evaluations for Unlicensed Personnel indicated training and competency evaluations of ULPs would be conducted by an RN, or another instructor may provide the training in conjunction with the RN and shall include: -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -medication, exercise and treatment reminders;	01370		

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01370	Continued From page 40 -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders -basic nutrition, meal preparation, food safety, and assistance with eating -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assisted devices. The licensee's undated Personnel Files/Employee Records policy indicated the licensee would maintain a current employee file on each employee and contain the required regulation documents. Employee records for unlicensed personnel would contain evidence of completed competency evaluation, conducted by an RN for delegated nursing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive,	01380		

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01380	Continued From page 41 and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of two unlicensed personnel (ULP)-C, ULP-D). 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: ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's employee record lacked evidence ULP-C received the following require training and/or competencies: -reading and recording temperature, pulse, and respirations of the resident; and -safe transfer techniques and ambulation.	01380		

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01380	Continued From page 42 On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. At 8:48 a.m., the surveyor observed ULP-C monitor R8's blood pressure. On July 3, 2024, at 11:46 a.m., ULP-C stated she was trained, and competency tested by clinical nurse supervisor (CNS)-B. ULP-C stated she remembered CNS-B completing a checklist of tasks CNS-B observed ULP-C perform but was unable to recall each individual skill. ULP-D ULP-D had a hire date of January 27, 2024, to provide direct care services to the licensee's residents. On July 2, 2024, during the course of the survey, the surveyor observed ULP-D assist residents with transfers, escorting resident to the dining room, serving meals, and exercises. ULP-D's employee record lacked evidence ULP-D received the following required training and/or competencies: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On July 3, 2024, at 9:27 a.m., CNS-B stated staff training records were in paper form and CNS-B completed staff competency evaluations in person before ULPs were allowed to work with residents. CNS-B stated ULP-D does not administer medication and assists with resident cares, transfers and ambulation, compression stockings, and vital signs. CNS-B stated she completed ULP-D's competency evaluations; however, was unable to find ULP-D's training	01380		

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01380	Continued From page 43 records. CNS-B stated she completed ULP-C's medication training and competency evaluations and was unable to find all ULP-C's competency evaluations. The licensee's undated Training and Competency Evaluations for Unlicensed Personnel indicated training and competency evaluations of ULPs would be conducted by an RN (registered nurse), or another instructor may provide the training in conjunction with the RN and shall include: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. The licensee's undated Personnel Files/Employee Records policy indicated the licensee would maintain a current employee file on each employee and contain the required regulation documents. Employee records for unlicensed personnel would contain evidence of completed competency evaluation, conducted by an RN for delegated nursing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being	01440		

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01440	Continued From page 44 performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not 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 licensee for one of one unlicensed personnel (ULP)-D. 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:	01440		

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01440	Continued From page 45 ULP-D had a hire date of January 27, 2024, to provide direct care services to residents of the facility. ULP-D's June 2024, timecard indicated ULP-D worked the following 6:00 a.m. to 2 p.m., shifts: -June 1 and 2, 2024; -June 10, 2024; -June 14-16, 2024; -June 20, 2024; -June 25 and 26, 2024; and -June 28 and June 29, 2024. On July 1 through July 2, 2024, during the course of the survey, the surveyor observed ULP-D assist residents with transfers, escorting resident to the dining room, serving meals, and ambulating with residents in the hallways. On July 3, 2024, at 9:27 a.m., clinical nurse supervisor (CNS)-B stated she was unable to find documentation indicating a registered nurse completed a 30-day supervision of a delegated task for ULP-D. The undated licensee's Supervision of ULP policy indicated ULP must be supervised by an RN within 30 days after the individual begins working for the licensee and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 46 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 47 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1,	01470		

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01470	Continued From page 48 2021. On July 2, 2024, at 7:40 a.m., the surveyor observed ULP-C administering R6's scheduled morning medications. ULP-D ULP-D had a hire date of January 27, 2024, to provide direct care services to residents of the facility. On July 1, 2024, through July 2,2024, during the course of the survey, the surveyor observed ULP-D assist residents with transfers, escorting resident to the dining room, serving meals, and ambulating with residents in the hallways. ULP-C and ULP-D's employee record lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services to the licensee's residents: -an overview of the 144G statutes; -assisted living Bill of Rights; -review of types of Assisted Living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -hearing loss (optional). On July 3, 2024, at 10:38 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee's training and competencies were from their previous comprehensive home care orientation material and did not meet all the assisted living training requirements for 144G statues. CNS-B stated the licensee was in the process of getting a new computer program that aligned with the assisted living 144G regulations and planned on	01470		

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01470	Continued From page 49 purchasing new policies and procedures that would also align with 144G regulations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	Continued From page 50 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct services completed the required annual training for two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01500		

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01500	Continued From page 51 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: CNS-B CNS-B had a hire date of October 1, 2018, under the comprehensive home care license and began to provide assisted living services on August 1, 2021. ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began to provide assisted living services on August 1, 2021. On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. CNS-B and ULP-C's employee records lacked evidence CNS-B and ULP-C's successfully completed annual training as required to include: -reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -review of provider's policies and procedures -principles of person-centered planning/service delivery; -hearing loss (optional); and -Tuberculosis training.	01500		

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01500	Continued From page 52 On July 3, 2024, at 10:03 a.m., CNS-B stated she had not completed any additional training since August 2023, which did not meet the annual training assisted living 144G regulation. CNS-B stated the licensee's Orientation/Review Sign-in Sheet dated August 30, 2023, did not contain the required training noted above. CNS-B confirmed ULP-C's employee records lacked evidence ULP-C completed the required annual training. The licensee's undated Required Annual Staff Training policy indicated all staff of the licensee that perform direct services would complete a minimum of eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not	01530		

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01530	Continued From page 53 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C, ULP-D) received the required amount of dementia care training in the required time frame. 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: ULP-C ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began to provide assisted living services on August 1, 2021.	01530		

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01530	Continued From page 54 On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. At 8:48 a.m., the surveyor observed ULP-C monitor R8's blood pressure. ULP-C's employee record lacked evidence ULP-C completed two hours of annual dementia training. ULP-D ULP-D was hired on January 27, 2024, to provide direct care services to residents of the facility. On July 1, 2024, through July 2, 2024, the surveyor observed ULP-D assist residents with transfers, escorting residents to the dining room, serving meals, and ambulating with residents in the hallways. ULP-D employee record included 7.25 hours of dementia training; however, lacked evidence ULP-D completed eight hours of dementia training within 160 working hours of employment start date. On July 3, 2024, at 10:38 a.m., CNS-B reviewed ULP-C and ULP-D's employee file and confirmed the employee records lacked documentation ULP-C completed annual dementia training. CNS-B stated ULP-D had worked more than 160 hours since start date and ULP-D's record lacked documentation a total of eight hours of initial dementia training. The licensee's Dementia Training policy dated September 14, 2018, indicated all staff would complete two hours of additional training for each 12 months of work thereafter. The licensee's undated Description of Dementia	01530		

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01530	Continued From page 55 Training for all Staff indicated eight (8) hours of training for Alzheimer's Disease and other related disorders were required for all staff during initial orientation and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (cook (C)-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01550		

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01550	Continued From page 56 The findings include: C-J was hired on February 5, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. During the survey, the surveyor observed C-J prepare and serve resident meals. C-J's training records indicated C-J lacked evidence C-J completed the required two hours of dementia training in the year 2023. On July 3, 2024, at 10:11 a.m., clinical nurse supervisor (CNS)-B stated food service manager (FSM)-K was responsible for kitchen staff training and FSM-K was currently out of the country. The licensee's undated Dementia Care Training policy indicated non-direct care staff would complete a minimum of two hours of training on topics related to dementia for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01560 SS=E	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include:	01560		

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01560	Continued From page 57 (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia training included all the required content for two of two (unlicensed personnel (ULP)-C, ULP-D.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 1, 2024, at 10:30 a.m., during entrance conference, clinical nurse supervisor (CNS)-B stated the employee training records were all in paper form and CNS-B was aware of the required employee training content. ULP-C	01560		

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01560	Continued From page 58 ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began to provide assisted living services on August 1, 2021. On July 2, 2024, at 8:28 a.m., the surveyor observed ULP-C administering R3's scheduled morning medications. At 8:48 a.m., the surveyor observed ULP-C monitor R8's blood pressure. ULP-C's employee record lacked evidence ULP-C received the following dementia training: -communication skills; and -person-centered planning and service delivery. ULP-D ULP-D was hired on January 27, 2024, to provide direct care services to residents of the facility. On July 1, 2024, through July 2,2024, the surveyor observed ULP-D assist residents with transfers, escorting resident to the dining room, serving meals, and ambulating with residents in the hallways. ULP-D's employee record lacked evidence ULP-D received the following dementia training: -the explanation of Alzheimer's disease and other dementia; and -person-centered planning and service delivery. On July 3, 2024, at 10:38 a.m., CNS-B reviewed ULP-C and ULP-D's employee file and confirmed the employee records lacked the required dementia care training content noted above upon orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01560		

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01560	Continued From page 59 (21) days	01560		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive change of condition assessment following hospitalization for one of one resident (R3). In addition, the license failed to ensure resident assessments were completed using the uniform assessment tool for	01620		

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01620	Continued From page 60 two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 1, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated resident assessments would be conducted with a change in resident condition or hospital returns. CHANGE OF CONDITION ASSESSMENT R3's diagnoses included neoplasm of the prostate, chronic pain, spinal stenosis, and lymphedema. R3's Service Plan dated April 16. 2024, indicated R3 received assistance with housekeeping, laundry, medications administration, skin care treatments and ace wraps. R3's progress note dated April 21, 2024, indicated R3's was disorientated, pale in color, had a low oxygen saturation level and was transferred to the hospital via ambulance. R3's progress note dated May 13, 2024, indicated R3 was discharged from the hospital and returned to the facility. R3's record did not include a change of condition assessment by the RN upon return from the	01620		

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01620	Continued From page 61 hospital. UNIFORM ASSESSMENT TOOL R2 diagnoses included diabetes type II, depressive disorder, and chronic obstructive pulmonary disease (COPD). R2's Service Plan dated April 28, 2024, indicated R2 received assistance with housekeeping, laundry, medication administration, dressing and bathing assistance, and blood glucose (blood sugar) monitoring. R2 and R3's Client (resident) Monitoring 90 Day Reassessment Form dated June 21, 2024, and June 10, 2024, lacked the following content of the uniform assessment tool: -the resident's personal lifestyle preferences, including: -sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; and -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. - physical health status including: -a review of relevant health history and current health conditions including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -infectious conditions; - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter	01620		

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01620	Continued From page 62 medications, and supplements, and for each: -the reason taken; -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -the dosage; -the frequency of use; -the route administered or taken; -any difficulties the resident faces in taking the medication; -the resident's preferences in how to take medication; -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 resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: -risk for falls including history of falls; -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern;	01620		

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01620	Continued From page 63 -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including: -the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -the scope of decision-making authority of a substitute decision maker. On July 2, 2023, at 1:01 p.m., CNS-B stated R3's record did not include an assessment after R3 returned from the hospital and should have had an assessment completed upon R3's return from the hospital. CNS-B stated the licensee only used the Master Nursing Assessment with the required content noted in the uniform assessment tool for the initial and annual resident assessments. CNS-B confirmed the licensee's Monitoring and Reassessment 90-day Visit did not include required content noted above in the uniform assessment tool. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08,	01620		

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01620	Continued From page 64 subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for	01730		

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01730	Continued From page 65 monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01730		

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01730	Continued From page 66 The findings include: During entrance conference on July 1, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to include medication storage. R2 R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease, and chronic obstructive pulmonary disease. On July 2, 2024, at 8:22 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled morning medications. R2's Service Plan dated March 23, 2024, included medication management services. R2's Service Plan had an area to check for filling of medication dispensers, reordering and storage of medications and was blank. R2's Initial Assessment dated March 23, 2024, indicated R2 required assistance with medications. R2's Medication Administration Assessment dated May 31, 2024, indicated R2's required assistance with medications and R2's medications would be stored by the provider. R3 R3's diagnoses included malignant neoplasm of prostate (prostate cancer), chronic obstructive pulmonary disease, diabetes type II, and chronic pain. On July 2, 2024, at 8:28 a.m., the surveyor	01730		

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01730	Continued From page 67 observed ULP-C administering R3's scheduled morning medications. R3's Service Plan dated April 6, 2023, included medication management services. R3's Service Plan had an area to check for filling of medication dispensers, reordering and storage of medications and was blank. R3's Annual Assessment dated March 29, 2024, indicated R3 required assistance with medication management. R2 and R3's record lacked a medication management plan to include the following required content: - identification of persons responsible for monitoring medication supplies and ensure that medication refills are ordered on a timely basis. On July 2, 2024, at 12:05 p.m., CNS-B stated the licensee's assessments do not address who was responsible for ordering resident medications. CNS-B confirmed R2 and R3's record did not identify the responsible person for ordering resident medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the	01750		

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01750	Continued From page 68 proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific instructions were in the resident record related to administering medications according to manufacturer's instructions for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease, and chronic obstructive pulmonary disease (COPD). R2's Service Plan dated March 28, 2024, indicated R2 received medication administration. R2's prescriber orders dated June 27, 2024, included Trelegy Ellipta 100-62.5-25 micrograms	01750		

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01750	Continued From page 69 (mcg) inhale one puff by mouth once a day for COPD. On July 2, 2024, at 8:24 a.m., unlicensed personnel (ULP)-C administered R2's morning scheduled medication, then handed R2 her Trelegy Ellipta inhaler. R2 inhaled one puff of the medication and handed the inhaler back to ULP-C and ULP-C exited R2's room. ULP-C did not instruct R2 to rinse her mouth after the use of the inhaler. ULP-C documented medications administered in R2's electronic mediation administration record (EMAR). ULP-C stated she did not instruct R2's to rinse her mouth after using her inhaler because R2's EMAR did not instruct to rinse mouth after the use of the inhaler. R2's June and July 2024, EMAR listed Trelegy Ellipta 100-62.5 mcg to inhale one puff by mouth once daily for chronic obstructive pulmonary disease (COPD); however, did not include to rinse mouth after use of the inhaler. On July 3, 2024, at 4:23 p.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated residents should be offered to rinse their mouth after inhaler administration. CNS-B further stated, instructions to rinse mouth after use of inhalers was not written on the resident's EMAR. The manufacturer's instructions for Trelegy Ellipta inhaler dated December 2022, directed to rinse mouth with water after use of the inhaler and spit the water out. The licensee's Inhalers policy indicated to provide the opportunity to rinse mouth after the use of inhaler. The licensee's undated Medication Management	01750		

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01750	Continued From page 70 Services Provided by Unlicensed Personnel policy indicted prior to a ULP providing delegated medication administration, the RN must specify, in writing, specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R2) who received inhaler administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 71 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: R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease, and chronic obstructive pulmonary disease (COPD). R2's Service Plan dated March 28, 2024, indicated R2 received medication administration. R2's prescriber orders dated June 27, 2024, included Trelegy Ellipta 100-62.5-25 micrograms (mcg) inhale one puff by mouth once a day for COPD. On July 2, 2024, at 8:24 a.m., unlicensed personnel (ULP)-C administered R2's morning scheduled medication, then handed R2 her Trelegy Ellipta inhaler. R2 inhaled one puff of the medication and handed the inhaler back to ULP-C and ULP-C exited R2's room. ULP-C did not instruct R2 to rinse her mouth after the use of the inhaler. ULP-C documented medications administered in electronic mediation administration record (EMAR). ULP-C stated she did not instruct R2's to rinse her mouth after using her inhaler because R2's EMAR did not instruct to rinse mouth after the use of the inhaler. R2's June and July 2024, EMAR listed Trelegy Ellipta 100-62.5 mcg to inhale one puff by mouth once daily for chronic obstructive pulmonary	01760		

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01760	Continued From page 72 disease (COPD); however, did instruct to rinse mouth after use of the inhaler. On July 3, 2024, at 4:23 p.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated residents should be offered to rinse their mouth after inhaler administration. CNS-B further stated instructions to rinse mouth after use of inhalers was not written on the resident's EMAR. The manufacturer's instructions for Trelegy Ellipta inhaler dated December 2022, directed to rinse mouth with water after use of the inhaler and spit the water out. The licensee's undated Inhalers policy indicated to provide the opportunity to rinse mouth after the use of inhaler. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to	01790		

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01790	Continued From page 73 the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed	01790		

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01790	Continued From page 74 personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-C followed the licensee's written procedure for providing medications for residents having unplanned time away for one of one resident (R5). In addition, the licensee failed to ensure one of one ULP (ULP-C) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away; furthermore, the licensee failed to develop a procedure for unplanned time away medications, as required. This had the potential to affect all residents receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of July 14, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01790		

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01790	Continued From page 75 On July 3, 2024, at 10:53 a.m., R5 was observed to inform ULP-C she would be going out for the day and would not be returning until supper and requested any medications to be sent with her. ULP-C reviewed R5's medication administration record and stated R5 received acetaminophen at noon. ULP-C prepared R5's acetaminophen 500 milligrams (mg) two tablets and put into a small clear plastic baggie, wrote the name of the medication and administration time on the baggie and handed the baggie to R5. ULP-C did not send any medication instructions for R5's acetaminophen. ULP-C's employee record lacked evidence to indicate ULP-C had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On July 3, 2024, at 11:46 a.m., ULP-C stated when a resident goes out for the day, she was trained to put the resident's medication in a plastic baggie and write the name of the medications and time to be taken on the baggie to send with the resident or resident's representative and verbally reviews the medication instructions at that time. ULP-C stated she was unaware if there was a written procedure on preparing and sending medications with residents. On July 3, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-B stated staff follow the instructions in Eldermark (electronic software program) in preparing medications to be sent with a resident when a resident goes out on a leave of absence. CNS-B stated if a resident is gone for more than a day, staff would send the medication	01790		

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01790	Continued From page 76 administration record with the resident, otherwise, writes the name and time of the medications on the baggie. CNS-B stated staff were trained on planned and unplanned time away procedure; however, does not document training or competency evaluations in the employee record. The licensee's undated Unplanned Time Away policy indicated for unplanned time away when a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for length of the anticipated absence. The resident, or resident's representative, must be provided written information on medications, including any specific any special instructions for administering or handling the medications. For unplanned time away when a licensed nurse is not available, a pharmacist or licensed nurse was not available, the registered nurse may delegate this task to unlicensed personnel. The registered nurse would train the unlicensed staff and determine the unlicensed staff was competent to follow the procedures for giving medications to residents. The registered nurse would develop written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that were prescribed for the client. The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to given to the client or client's representative; - how the unlicensed staff must document in the	01790		

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01790	Continued From page 77 resident's record that medications have been given to the client or client's representative, 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; - how the RN shall be notified that medications have been given to the client or client's representative and whether the RN needs to be contacted before the medications are given to the client or the client's representative; -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 -how the ULP 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34011	A. BUILDING: _____ B. WING _____	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE VILLA LLC	200 MINNESOTA AVENUE EAST SEBEKA, MN 56477

(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
01890	Continued From page 78 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained and monitored for expired dates when stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on July 1, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the license provided medication management services to include medication storage. On July 1, 2024, at 12:34 p.m., the surveyor observed the medication storage cart with CNS-B. CNS-B confirmed the following: -R6's glucosamine/chondroitin 1500/1200 milligrams (mg) had expired June 2024; -R7's opened bottle of anti-diarrheal 2 mg had expired June 2022; -an opened bottle of stock antacid 500 mg had expired June 2021; -an opened bottle of stock pain reliever 500 mg had expired November 2022; -an opened bottle of stock ibuprofen 200 mg; and -an opened bottle of stock anti-diarrheal soft gel 2 mg had expired November 2022.	01890		

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01890	Continued From page 79 No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R2) who received blood glucose monitoring by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	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 80 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: R2's diagnoses included diabetes type II, depressive disorder, peripheral vascular disease, and chronic obstructive pulmonary disease (COPD). On July 1, 2024, at 11:53 a.m., the surveyor observed unlicensed personnel (ULP)-C hand R2 her FreeStyle Libre device (a device that measures glucose levels through a small sensor applied to the back of the arm) to scan and R2 reported of a blood glucose result of 360 milligrams per deciliter (mg/dl). ULP-C administered R2 14 units of Novolog (rapid-acting) insulin into R2's left lower abdomen. R2's Service Plan dated March 23, 2024, included blood glucose monitoring four times a day. R2's Treatment and Therapy Plan dated March 23, 2024, indicated R2 received blood glucose monitoring and specific parameters were located on R2's medication administration record (MAR) or treatment administration record (TAR). R2 record indicated to notify R2's provider if R2's blood glucose level was greater than 450 mg/dl; however, did not include written parameters of when to notify the nurse or provider of a low blood	01950		

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01950	Continued From page 81 glucose level. On July 1, 2024, at 12:32 p.m., clinical nurse supervisor (CNS)-B stated R2's record did not include written parameters for a low blood glucose level and would temporarily add it as a nursing order and contact R2's provider for orders. The licensee's undated Delegated Nursing Services policy indicated a registered nurse may delegate nursing services to ULP after the RN specify, in writing, specific instruction for each client and document those instructions in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R2, R3) who utilized bed rails and for one of one resident R4 who utilized a consumer bedrail.	02310		

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02310	Continued From page 82 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on July 1, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated they had residents who utilized hospital beds with attached upper bedrails and one resident who had a consumer rail attached to the mattress. R2 R2's diagnoses included diabetes type II, arthritis, and chronic obstructive pulmonary disease. On July 2, 2024, at 8:24 a.m., the surveyor observed R2 had bilateral bed rails in the upright position, attached to R2's hospital bed. R2's Service Plan dated March 23, 2024, indicated R2 required assistance with dressing, bathing, housekeeping, laundry, medications administration and blood glucose monitoring. R2's Side Rail Assessment dated March 23, 2024, indicated bedrails to promote independence, R2 and or R2's family were aware of the risks involved with bedrails use. R2's record lacked a comprehensive assessment on the use of bedrails to include measurements	02310		

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02310	Continued From page 83 of the entrapment zones according to the Food and Drug Administration (FDA) guidelines, and the bed rails were FDA compliant. R3 R3's diagnoses included neoplasm of the prostate, chronic pain, spinal stenosis, and lymphedema. On July 2, 2024, at 8:03 a.m., the surveyor observed R3 had bilateral bed rails in the upright position, attached to R3's hospital bed. On July 2, 2024, at 10:41 a.m., R3 stated he used the bedrails to help reposition himself while in bed and to assist in getting in and out of bed. R3's Service Plan dated April 16. 2024, indicated R3 required assistance with housekeeping, laundry, medications administration, skin care treatments and ace wraps. R3's Side Rail Assessment dated April 11, 2024, indicated while R3 was in the hospital, R3 verbally requested the use of bedrails to promote independence with bed mobility; however, R3 was in the hospital at the time of the request and was unable to participate in a bedrail assessment. R3's 90-Day Assessment dated June 10, 2024, did not include an assessment of R3's bedrails. R3's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and further lacked on going assessment for the use of an assisted device as required in the uniform assessment tool.	02310		

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02310	Continued From page 84 R4 R4's diagnoses included cerebral vascular accident (CVA/stroke). On July 2, 2024, at 11:08 am the surveyor observed a black U-shaped consumer bedrail attached to R4's left upper side of the bed. The bedrail secured with a strap between the mattresses and box spring. R4's Service Plan, unauthenticated, indicated R4 required assistance with bathing, dressing, toileting, transfers/mobility, housekeeping, laundry, and medications administration. R4's progress notes dated April 3, 2023, indicated R4's family requested to install a quarter bedrail for independence with bed mobility. R4's bedrail had full retention straps which eliminated any gaps between the mattress and rail and gap inside bedrail measured 25 centimeters (cm). R3 demonstrated appropriate use of rail. R4's Annual Assessment date June 24, 2024, indicated R4 required the assist of one for getting in and out of bed and had a quarter side rail. R4's record lacked the following: -type of consumer bed rail being used; -the consumer bed rail was installed be manufacturer directions; and -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. On July 2, 12:39 p.m., CNS-B stated R4's family purchased R4's consumer bedrail and the licensee installed the bedrail. CNS-B stated she did not check the Consumer Product Safety	02310		

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02310	Continued From page 85 Commission (CSPC) website for recalls because she knew what the recalled consumer bedrails looked like. CNS-B stated she did not document measurements of entrapment zones for bedrails because all of the residents who currently had a hospital bed with bedrails were newer and came from the medical supply company and should meet the FDA requirements. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail. - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail. - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks): - The resident's preferences: - Installation and use according to manufacturer's guidelines: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310		

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02310	Continued From page 86 interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 26, 2023, current recommendations for recall include the following "The United States Consumer Product Safety Commission (CSPC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Side Rail policy dated August 1, 2021, when the licensee was made aware a resident utilized side rails on a bed, the licensee would educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy would be followed regardless of who owns or is supplying the side rail. The RN would conduct an assessment to identify intended purpose of the side rail and risks. The side	02310		

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02310	Continued From page 87 design would be consistent with the FDA's 2006 recommended dimensional measurement to reduce entrapment. Education provided would be documented in the resident record. The licensee's undated Side Rail indicated it is the policy of the licensee to limit the use of medical devices to those that are considered "safe", based on current standards of practice. When the licensee was aware a home care client Is utilizing side rails (a medical device) on a bed, the licensee shall assess the use, educate the resident, and, when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. "Safe" shall be defined as as meeting all the requirements listed below: -side rails is used consistent with the manufacturer's directions; -side rails should be installed securely and maintained in good operating; -side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zone 1, 2, and 3 and must not exceed 4.75 inches. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy of correction order 2310 was not removed prior to survey exit on July 3, 2024, and noncompliance remains at a widespread scope and level three (l).	02310		

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03090	Continued From page 88	03090		
03090 SS=F	144.6502, 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." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required signage 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 to the facility. 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 the residents). The findings include: On July 1, 2024, at 12:20 p.m., during a facility tour with clinical nurse supervisor (CNS)-B, the surveyor did not observe signage to disclose electronic monitoring. CNS-B stated the licensee did not have any electronic monitoring in building, so she did not think the licensee had to post electronic monitoring signage.	03090		

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03090	Continued From page 89 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls
218-332-5150

Type: Full
Date: *07/02/24*
Time: 11:00:00
Report: 1049241136

Food and Beverage Establishment Inspection Report

Location:
Providence Villa Llc
200 Minnesota Avenue East
Sebeka, MN56477
Wadena County, 80

Establishment Info:
ID #: 0038825
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188379162
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE EMPLOYEE CHELSEA OLSON CURRENTLY HAS AN ACTIVE CFPM CERTIFICATE. THE CFPM CERTIFICATE WAS NOT POSTED AT THE ESTABLISHMENT. PIC INSTRUCTED TO POST THE CFPM CERTIFICATE.

Comply By: 07/02/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE STOVE TOP AND THE INSIDE OF THE COUNTERTOP OVEN HAD ACCUMULATION OF FOOD DEBRIS.

Comply By: 07/02/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

THE FLOOR AND THE WALL BY THE HAND SINK WERE UNCLEAN. PIC INSTRUCTED TO CLEAN THE FLOOR AND WALL ACCORDINGLY.

Comply By: 07/02/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37.5 Degrees Fahrenheit - Location: 3 Bean Hotdish
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38.5 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30.5 Degrees Fahrenheit - Location: Grapes
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30.5 Degrees Fahrenheit - Location: Sandwich
Violation Issued: No

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

INSPECTOR MET WITH STATE EVALUATOR, SATIVA BUSHEY, AND ESTABLISHMENT REPRESENTATIVE, MIRIAM DOZIER. NO FOLLOW-UP INSPECTION REQUIRED.

KITCHEN HAS TILE FLOORING, SMOOTH DROP DOWN CEILING AND FRP WALLS.

THE ESTABLISHMENT IS USING QUAT SANITIZER AT 200 PPM IN THEIR SANITIZER BUCKET. THE ESTABLISHMENT IS USING AN APPROVED CHLORINE BASED SANITIZER FOR THEIR 3 COMPARTMENT SINK.

Things to Remember:

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

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

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

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

Type: Full
Date: *07/02/24*
Time: 11:00:00
Report: 1049241136
Providence Villa 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 Minnesota Department of Health inspection report number 1049241136 of 07/02/24.

Certified Food Protection Manager Chelsea Olson

Certification Number: FM108977 Expires: 07/19/24

Signed: _____
Establishment Representative

Signed: *Stephanie Reynolds*

Stephanie Reynolds
Public Health Sanitarian
Fergus Falls
218-332-5179
stephanie.reynolds@state.mn.us

Report #: 1049241136

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Fergus Falls District
2312 College Way
Fergus Falls

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/02/24
Time In 11:00:00
Time Out

Providence Villa Llc	Address: 200 Minnesota Avenue East	City/State: Sebeka, MN	Zip Code: 56477	Telephone: 2188379162
License/Permit #: 0038825	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status					COS	R
Surpervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	(IN)	OUT N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	(N/A) N/O	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT N/A	N/O	Food separated and protected		
16	(IN)	OUT N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	(IN)	OUT N/A	N/O	Proper cooking time & temperature		
19	(IN)	OUT N/A	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A) N/O	Proper cooling time & temperature		
21	IN	OUT	(N/A) N/O	Proper hot holding temperatures		
22	(IN)	OUT N/A		Proper cold holding temperatures		
23	(IN)	OUT N/A	N/O	Proper date marking & disposition		
24	(IN)	OUT N/A	N/O	Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	(IN)	OUT N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	(IN)	OUT N/A		Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/02/24

Inspector (Signature) Stephanie Reynolds