DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 6, 2023

Licensee
The Homestead At Rochester
5530 Ballington Road Northwest
Rochester, MN 55901

RE: Project Number(s) SL32647015

Dear Licensee:

On September 8, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 30, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 30, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 30, 2023, found not corrected at the time of the September 8, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0510-Infection Control Program-144g.41 Subd. 3 - $500.00

The details of the violations noted at the time of this follow-up survey completed on September 8, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up survey completed on September 8, 2023, we identified the following violation(s):

0700-Resident Record-144g.43 Subdivision 1
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1880-Storage Of Medications-144g.71 Subd. 19

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	R 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL32647015 On September 5, 2023, through September 8, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 30, 2023. At the time of the survey, there were 51 residents: 50 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{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 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during medication and treatment administration by three of four unlicensed personnel (ULP-I, ULP-R, and ULP-S.) 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	{0 510}		

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{0 510}	Continued From page 2 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 continuous observation on September 6, 2023, at 6:45 a.m. ULP-I put on gloves and prepared oral medications for administration. ULP-I then administered medications to R12. ULP-I noted R12's shoes were on the wrong feet. ULP-I removed R12's shoes, adjusted sock and put shoes back on. ULP-I removed gloves, used hand sanitizer and then placed clean gloves. ULP-I began preparing medications for administration for R13. With the gloves on, ULP-I went to R13's room, woke her up, and applied lotion to bilateral lower legs. ULP-I removed gloves and applied TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling) to R13. ULP-I put on gloves, administered oral medications, used a wet washcloth to wash R13's face, and applied a medicated cream to her face. ULP-I then removed the gloves, returned to the medication cart, and used hand sanitizer. R18 was refusing assistance from another staff, so ULP-I assisted R18, while sitting on the toilet, to dress her lower extremities, placing pants, socks and shoes. ULP-I then returned to the medication cart and used hand sanitizer. ULP-I set up medications for R14. While wearing gloves, ULP-I removed R14's sock and shoe, applied medicated lotion to R14's leg and foot, and put her sock and shoe back on. ULP-I removed her gloves, used hand sanitizer, and removed medications for R15. ULP-I put on gloves, set up	{0 510}		

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{0 510}	Continued From page 3 and administered oral medications to R15, removed gloves, and used hand sanitizer. ULP-I failed to wash hands between residents throughout the observation. During continuous observation on September 6, 2023, at 7:31 a.m. ULP-S had medications prepared for administration to R16. ULP-S entered R16's room, put on gloves, retrieved blood glucose testing supplies, and tested R16's blood sugar. ULP-S removed gloves, left R16's room and used hand sanitizer. ULP-S then began setting up medications for the next resident. ULP-S failed to wash hands after blood glucose monitoring and between residents. During continuous observation on September 6, 2023, at 7:48 a.m. ULP-R used hand sanitizer and set up oral medications, eye drops, insulin, and medicated ointment for R17. In R17's room, ULP-R put on gloves, administered oral medications, tested R17's blood glucose, and administered insulin. ULP-R removed soiled gloves, applied clean gloves, and applied medicated ointment to R17's lower back. ULP-R removed gloves, placed clean gloves and administered the eye drops. ULP-R removed gloves, used hand sanitizer and returned to medication cart. ULP-R failed to wash hands between medication and treatment tasks that had the potential for contamination and between residents. On September 6, 2023, at 8:23 a.m. registered nurse (RN)-B stated staff should be washing hands between residents, not just using hand sanitizer, especially if they are completing cares, administering creams or ointments, and checking blood glucose.	{0 510}		

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{0 510}	Continued From page 4 The licensee's Hand Washing policy dated August 1, 2023, identified "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: · Before, during, and after preparing food · Before eating food · Before and after caring for someone who is sick · Before and after treating a cut or wound · After using the toilet · After changing diapers or cleaning up after someone who has used the toilet · After blowing your nose, coughing, or sneezing · After touching an animal or animal waste · After handling pet food or pet treats · After touching garbage" "Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination." "Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. There is no limit to the number of times you use ABHS before you must use soap and water. A good rule of thumb though, is to wash with soap and water when hands are visibly soiled, after completing cares for someone with c. diff or norovirus, and when the hands have a "filmy" feel to them."	{0 510}		

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{0 510}	Continued From page 5 The licensee's undated, Administration of Medication by Unlicensed Personnel policy identified "Unlicensed personnel that will provide assistance with medication administration will be trained and competency tested by the RN" included "Infection control precautions that must be followed when administering medications". The licensee's undated, Administration of Oral Medications policy identified "When administering oral medications, open the dosage box to the correct day and time and pour the medications into the client's hand or medication cup. Do not touch the pills with your hands." No further information was provided.	{0 510}		
{0 660} SS=D	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 6 by: Based on observation, interview, and record review, the licensee failed to ensure employee tuberculosis (TB) symptom and history screenings and a two-step tuberculin skin test (TST) were completed and documented for one of three employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 6, 2023, at 6:45 a.m. ULP-I was observed administering medications to several residents. ULP-I began providing direct care services for the licensee on December 27, 2022. ULP-I's employee record identified a TB symptom screening tool dated December 12, 2022, and a single TST completed on October 28, 2022. ULP-I's employee record lacked evidence of a second step TST as required. On September 7, 2023, at 12:04 p.m. RN-B stated ULP-I was a rehire and there was no proof of a second step TST for ULP-I in the employee file upon rehire. The licensee's undated, Infection Prevention and Control Manual TB Exposure Control Plan,	{0 660}		

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{0 660}	Continued From page 7 identified "All staff will have an initial two-step Tuberculin Skin Test (TST) upon hire or an IGRA [Interferon Gamma Release Assay- a blood test for TB] unless otherwise indicated, a symptom evaluation for those without documented prior TB disease or LTBI [latent tuberculosis infection] and an individual TB risk assessment." No further information was provided.	{0 660}		
0 700 SS=E	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, two of two employees (unlicensed personnel (ULP)-Q, ULP-I) failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be	0 700		

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0 700	Continued From page 8 pervasive). The findings include: On September 5, 2023, at 3:52 p.m. unlicensed personnel (ULP)-Q set up medications for R10, locked the medication cart, and went down the hallway to R10's apartment. ULP-Q failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving, and it was visible to other residents, staff, and visitors. At 4:02 p.m., ULP-Q returned to the medication cart and documented administration of the medications. At 4:16 p.m., ULP-Q stated when she leaves the cart she changes it to a home screen without identifying resident information. On September 6, 2023, at 6:45 a.m. ULP-I set up medications for R12, and went down the hallway to R12's apartment. ULP-I failed to lock the laptop screen prior to walking away. At 6:53 a.m., ULP-I set up medication for R13, and went down the hallway to R13's apartment. ULP-I failed to lock the laptop screen prior to walking away. At 7:05 a.m., ULP-I set up medications for R14, and went down the hallway to R14's apartment. ULP-I failed to lock the laptop screen prior to walking away. At 7:22 a.m., ULP-I set up medications for R15, and went down the hallway to R15's apartment. ULP-I failed to lock the laptop screen prior to walking away. Each time the laptop screen was left open it contained information including resident name and medications they were receiving, and it was visible to other residents, staff, and visitors. On September 6, 2023, at 8:22 a.m. registered nurse (RN)-B stated computer screens should be	0 700		

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0 700	Continued From page 9 locked or shut when staff are not at the medication cart so confidential information is not visible to other residents, staff, or visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	{0 810}		

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{0 810}	Continued From page 10 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: No further action required.	{0 820}		
{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	{01440}		

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{01440}	Continued From page 11 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of three unlicensed personnel (ULP-R). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	{01440}		

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{01440}	Continued From page 12 ULP-R began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 3, 2023. On September 6, 2023, at 7:48 a.m. ULP-R was observed administering oral medications, ointments, eye drops, insulin and checking blood glucose for R16. ULP-R's employee file lacked evidence a RN conducted direct supervision of staff performing a delegated task within 30 days of providing services. On September 7, 2023, 1:21 p.m. RN-B stated ULP-R transferred from the nursing home on August 3, 2023, and ULP-R's record lacked evidence of supervision of a delegated task within 30 days after performing delegated tasks. The licensee's Supervision of Licensed and Unlicensed Personnel policy undated, identified "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned." No further information was provided.	{01440}		
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision	{01470}		

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{01470}	Continued From page 13 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 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;	{01470}		

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{01470}	Continued From page 14 (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 two of four unlicensed personnel (ULP-R, ULP-I) received orientation to include the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-R ULP-R began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 3, 2023. On September 6, 2023, at 7:48 a.m. ULP-R was observed administering oral medications, ointments, eye drops, insulin and checking blood glucose for R16.	{01470}		

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{01470}	Continued From page 15 ULP-R's employee file lacked evidence of the following required orientation: (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 (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; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 7, 2023, at 8:17 a.m. registered nurse (RN)-B stated ULP-R transferred from the nursing home on August 3, 2023, and ULP-R should have completed the required orientation upon transfer to the assisted living. ULP-I ULP-I began providing services under the ALFDC license on December 27, 2022. On September 6, 2023, at 6:45 a.m. ULP-I was observed administering medications to several residents. ULP-I's employee file lacked evidence of the following required orientation: (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; (6) the principles of person-centered planning and	{01470}		

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{01470}	Continued From page 16 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; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 7, 2023, at 11:48 a.m. RN-B stated ULP-I was rehired on December 27, 2022, and should have completed the required orientation upon rehire. The licensee's undated, Home Care Orientation policy identified "At minimum, this orientation must include the following topics: a. An overview of Minnesota's home care law (MN Statutes §144A.43 to 144A.4798); b. An introduction and review of all of our agency's policies and procedures related to the provision of home care services; c. Handling emergencies and use of emergency services; d. Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes §626.556 and §626.557; e. The home care bill of rights (MN Statutes §l44A.44); f. Our program's system for receiving and responding to complaints, where to report complaints {for agencies that are the "arranged" home care agency in a housing -with-services establishment: the housing staff person a client may contact with home care concerns or issues, and information on the Office of Health Facility Complaints and the Common Entry Point and how clients, staff and others may contact these agencies with complaints;	{01470}		

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{01470}	Continued From page 17 g: The consumer advocacy services of the Ombudsman 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 h. A review of the types of home care services the employee will be providing and the scope of our agency's license." The policy failed to identify the required Assisted Living Orientation. No further information was provided.	{01470}		
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not 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:	{01540}		

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{01540}	Continued From page 18 Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-R) received the required amount of dementia care training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-R began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 3, 2023. On September 6, 2023, at 7:48 a.m. ULP-R was observed administering oral medications, ointments, eye drops, insulin and checking blood glucose for R16. ULP-R's employee file identified she had two and a half hours of dementia care training. ULP-R's file lacked evidence she had received the required eight hours of dementia training in the first 80 hours of employment. The licensee's daily staff schedule identified between August 28, 2023, and September 5, 2023, ULP-R worked 88 hours. On September 7, 2023, registered nurse (RN)-B stated ULP-R transferred from the nursing home on August 3, 2023, and she worked full time hours. She worked over 80 hours since transferring and should have completed the	{01540}		

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{01540}	Continued From page 19 required eight hours of dementia training. The licensee's Dementia Training Program Disclosure - Assisted Living with Dementia Care Licensure policy undated, identified "Training Topic Requirements for All New Hire Staff 1) An explanation of Alzheimer's Disease and other dementia's; 2) Assistance with activities of daily living; 3) Problem solving with challenging behaviors; 4) Communications skills; 5) Person-centered planning and service delivery; 6) Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and 7) Standards of dementia care including non-pharmacological dementia care practices that are person-centered and evidence-informed". For direct care staff "At least eight hours of training that includes the topics listed above. The training must be completed within 80 working hours of employment start date". No further information was provided.	{01540}		
{01560} SS=D	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: (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	{01560}		

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{01560}	Continued From page 20 (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 one of three unlicensed personnel (ULP-R) dementia care training in the required topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-R began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 3, 2023. On September 6, 2023, at 7:48 a.m., ULP-R was observed administering oral medications, ointments, eye drops, insulin and checking blood glucose for R16. ULP-R's employee file identified she had two and a half hours of dementia care training which included the following topics: - Alzheimer's Disease and Related Disorders: Behavioral and ADL (activities of daily living)	{01560}		

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{01560}	Continued From page 21 Management - Alzheimer's Disease and Related Disorders: Behavioral Management - Dementia Care: Ethical Considerations ULP-R's employee file failed to identify dementia training which included the required topics: - an explanation of Alzheimer's disease and other dementia's; - communication skills; and - person-centered planning and service delivery. On September 7, 2023, registered nurse (RN)-B stated ULP-R transferred from the nursing home on August 3, 2023, and she worked full time hours. She worked over 80 hours since transferring and should have completed the required eight hours of dementia training including all required topics. The licensee's Dementia Training Program Disclosure - Assisted Living with Dementia Care Licensure policy undated, identified "Training Topic Requirements for All New Hire Staff 1) An explanation of Alzheimer's Disease and other dementia's; 2) Assistance with activities of daily living; 3) Problem solving with challenging behaviors; 4) Communications skills; 5) Person-centered planning and service delivery; 6) Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and 7) Standards of dementia care including non-pharmacological dementia care practices that are person-centered and evidence-informed". For direct care staff "At least eight hours of training that includes the topics listed above. The training must be completed within 80 working	{01560}		

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{01560}	Continued From page 22 hours of employment start date". No further information was provided.	{01560}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a reassessment not to exceed 90 days was completed for one of four residents (R2).	{01620}		

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{01620}	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on September 25, 2020, with a diagnosis of dementia. R2's service plan dated September 22, 2022, indicated resident received assistance with medication management, bathing, dressing, toileting, and transfers. R2's record indicated a comprehensive 90-day assessment was completed on December 15, 2022, March 13, 2023, and September 6, 2023, which was 177 days after the previous assessment and after the surveyor entered for the follow up survey. On September 8, 2023, at 9:01 a.m. RN-B stated that R2's service plan was completed after the surveyor entered. There were three or four residents that the assessments were not completed yet for the plan of correction and R2 was one of them. After the surveyor entered on September 5, 2023, all remaining assessments were completed. The licensee's nuptial and Ongoing Resident Evaluations and Assessments policy dated August 1, 2021, identified "A Registered Nurse will complete the following nursing assessments using the Uniform Assessment Tool:	{01620}		

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{01620}	Continued From page 24 a. Pre-Admission Assessment of the prospective resident; b. 14-day assessment: completed up to 14-days after start of services; c. Resident reassessment and monitoring: completed periodically but no less than every 90-days; or d. Change in resident condition". No further information was provided.	{01620}		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	01640		

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01640	Continued From page 25 Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for three of five residents (R2, R16, R18). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted under the assisted living with dementia care (ALFDC) license on August 1, 2021. R2's care plan, identified as the service plan, last updated on August 11, 2022, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. R16 R16 was admitted under the ALFDC license on August 1, 2021. On September 6, 2023, at 7:31 a.m. unlicensed personnel (ULP)-S was observed administering medications and checking blood glucose for R16. R16's care plan, identified as the service plan, last updated on July 28, 2022, lacked a signature	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	R 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 26 or other authentication by the resident or by the facility, documenting agreement on the services to be provided. R18 R18 was admitted under the ALFDC license on April 10, 2023. R18's care plan, identified as the service plan, dated April 10, 2023, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. On September 8, 2023, registered nurse (RN)-B stated the process for correcting the service plans included reassessing the resident and setting up care conferences with the resident and/or representative to review the service plans and have them signed. Most service plans had been completed; however, the facility had not completed this process for R2, R16, and R18. The licensee's Admission Process for New Clients policy, undated, identified "Service Plan. Upon completion of the individualized initial nursing assessment, the RN develops a service plan with the client and/or the client's representative no more than 14 days after the initiation of home care services." "The RN and the client and/or the client's representative sign the service plan/care plan, and the RN gives a copy of the service plan/care plan to the client and/or the client's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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{01770}	Continued From page 27	{01770}		
{01770} SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for two of two residents (R8, R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R8 R8's medication administration record (MAR) for September 2023, identified the following - warfarin (blood thinner) 2 mg give two tablet by mouth in the evening every Monday, Wednesday, Thursday, Saturday, and Sunday and was signed off as administered on September 2, 3, 4, 2023. - warfarin 2 mg give 2.5 tablet by mouth in the evening every Tuesday, Friday, and was signed off as administered September 1, 2023, and September 5, 2023.	{01770}		

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{01770}	Continued From page 28 R8's progress note dated September 5, 2023, identified "1 week's worth of Coumadin [warfarin] was set up by author. Medication placed on medication cart. Orders verified." R8's record failed to identify documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup done at the time of setup. R13 On September 6, 2023, at 6:53 a.m. unlicensed personnel (ULP)-I was observed administering the following bubble packaged medications to R13: - hydroxurea (medication to treat cancer) 500 milligrams (mg) with a handwritten label that identified the instructions of "2 capsules daily". - multivitamin with handwritten label that identified the instructions of "1 tablet every day" Both labels failed to identify the route of administration and any prescription numbers associated with the medications. ULP-I stated the nurses set up the medications in the bubble packs. R13's MAR for September 2023, identified the following: - hydroxuria capsule 500 mg "give 3 capsules by mouth one time a day every Tuesday, Thursday, and Saturday" and was signed off as administered on September 2, 2023, and September 5th, 2023. - multivitamin tablet "give 1 tablet by mouth one time a day" and was signed off as administered September 1-5, 2023. Both medications had a handwritten note under the administration that stated "nurse sets up meds".	{01770}		

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{01770}	Continued From page 29 R13's progress note dated August 31, 2023, identified "31 days worth of multivitamin were set up today" R13's record failed to identify documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup done at the time of setup. On September 7, 2023, at 2:43 p.m. registered nurse (RN)-B stated the nurses were supposed to use a printed MAR and/or document in the progress notes the dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup at the time of setup. The licensee's Medication Management Services policy dated March 11, 2022, identified "Medication Set Up. When setting up medication for later administration the RN or LPN will: a. Verify that the dose and quantity of medications delivered is consistent with the prescription; b. Review prescribed medications to identify any contraindications or other concerns; c. Identify whether refills are needed and follow up to be sure the refill is available when needed;and d. Verify that medications for the previous period were administered as prescribed. If the nurse identifies any discrepancies or concerns when setting up medications, the nurse will complete appropriate follow up and documentation of the results of the follow up." No further information was provided.	{01770}		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication cart (memory care unit) was securely locked in substantially constructed compartments and permitted only authorized personnel to have access with records reviewed. This had the potential to affect all residents residing in the memory care unit and any 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 September 6, 2023, at 6:45 a.m. ULP-I set up medications for R12, and went down the hallway to R12's apartment. ULP-I failed to lock the medication cart prior to walking away. At 7:22 a.m., ULP-I set up medications for R15, and went down the hallway to R15's apartment. ULP-I failed to lock the medication cart prior to walking away.	01880		

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01880	Continued From page 31 On September 6, 2023, at 8:22 a.m. registered nurse (RN)-B stated medication carts should be locked when staff are not at the medication cart so residents, visitors, and other staff cannot access it. The licensee's Medication Management Services policy dated March 11, 2022, identified "Medication Management Policies and Procedures. The RN will develop and update as needed specific procedures for the following medication management activities:" which included "Controlling and storing medications including controlled substances." A pharmacy policy provided by the licensee for Storage and Expiration Dating of Medications, Biologicals dated August 1, 2018, identified the following: "The Community should ensure that only authorized Community staff, as defined by the Community, may have possession of the keys, access cards, electronic codes, or combinations which open drug storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other authorized personnel to administer or observe medications in compliance with Applicable Law. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
{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	{01890}		

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{01890}	Continued From page 32 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for three of four medication carts (assisted living, memory care three, memory care one). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: A review of medication carts was completed on September 6, 2023, between 6:47 a.m. and 7:11 a.m. during medication observations. Medication cart in the assisted living identified the following: R20 - latanoprost (eye drops for glaucoma) had an illegible open date - Rhopressa (eye drops for glaucoma) had an illegible open date - lubricant eye drops had a small pharmacy label that failed to identify the instructions for use.	{01890}		

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{01890}	Continued From page 33 - 2 vials of carboxymethylcellulose 0.5% eye drops (used for dry eyes) were in a foil package, there was no pharmacy label or box with a pharmacy label. Medication cart in memory care three identified the following: R21 - Rhopressa had an illegible open date Medication cart in memory care one identified the following: R22 - latanoprost had two bottles open and in use, one bottle had an open date of August 8, 2023, and the other bottle did not have an open date - artificial tears had a small prescription label that failed to identify the instructions. On September 6, 2023, at 8:22 a.m. registered nurse (RN)-B stated time sensitive medications should have legible open dates and all medications should have a pharmacy label with all required information. Latanoprost prescribing information dated September 16, 2014, identified latanaprost must be used within 28 days after opening the bottle and remaining contents showed be thrown away after 28 days. Rhopressa prescribing information dated December 2017, identified after opening it can be kept at 36-77 degrees Fahrenheit for six weeks. A pharmacy policy provided by the licensee for Medication Labels dated August 1, 2018, identified "All medications, regardless of source,	{01890}		

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{01890}	Continued From page 34 are labeled in accordance with state and federal laws and accepted practice standards." All labels were to contain the following: "Resident Name Name of medication Strength of medication Generic name of product if dispensed In place of brand name products Quantity dispensed Quantity of medication expressed in the appropriate unit of measure Medications in form intended for dilution or reconstitution, directions for such dilution or reconstitution. (Whenever possible, dilution reconstitution Is done at the Pharmacy) Expiration date and lot number Prescription number " Name of physician/Physician/Prescriber Date dispensed Number of refills remaining" "Labels should be securely attached to medications and expiration date and lot numbers will be visible." "If a label becomes illegible, soiled or damaged, the medication should not be used and should be re-ordered." "Medications that are in multiple dose vials (i.e., Insulin) or containers (i.e., bulk liquids) must have a label indicating the date the container was first opened and the date it expires." "Multi-dose vials expire 28 days after the date opened unless otherwise specified by the manufacturer." A pharmacy policy provided by the licensee for Storage and Expiration Dating of Medications, Biologicals dated August 1, 2018, identified: "5. Once any drug or biological package is opened, the Community should follow manufacturer/supplier guidelines with respect to	{01890}		

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{01890}	Continued From page 35 expiration dates for opened medications. 6. The Community should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels." No further information was provided.	{01890}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

Electronically Delivered

August 3, 2023

Licensee
The Homestead At Rochester
5530 Ballington Road Northwest
Rochester, MN 55901

RE: Project Number(s) SL32647015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $9,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	06/30/2023

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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: SL32647015 On June 26, 2023, through June 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 54 active residents; 53 receiving services under the Assisted Living with Dementia Care license. 1290: An immediate correction order was issued on June 27, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (l). 1750: An immediate correction order was issued on June 28, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (l). 2310: An immediate correction order was issued	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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	32647	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Continued From page 1 on June 28, 2023. The immediacy was removed; however, non-compliance remains at a level 3, pattern scope (H).	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;	0 250		

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0 250	Continued From page 2 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (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 interview and record review, the licensee failed to demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. 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	0 250		

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0 250	Continued From page 3 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 June 26, 2023, at 11:00 a.m., registered nurse (RN)-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 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, 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. * I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. * Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. * Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. * Reporting of Maltreatment of Vulnerable Adults. * Electronic Monitoring in Certain Facilities * I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. * I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. * I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 * 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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent (AA)-Z on May 25, 2022. The licensee had an assisted living license issued on June 1, 2023, with an expiration date of May 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified,	0 250		

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0 250	Continued From page 6 managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued: 0510, 0640, 0660, 1290, 1350, 1360, 1370, 1380, 1440, 1470, 1480, 1500, 1540, 1560, 1620, 1750, 1760, 1770, 1890, 1910, 1950, 1970, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. 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	0 480		

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0 480	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 8 by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during medication administration by one of four unlicensed personnel (ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered liquid and other oral medications to R7. While preparing the medication, she punched the meds into her ungloved hand and then placed them into the medication cup. - at 7:35 a.m., ULP-H set up medications for R8. R8 was in the dining room and ULP-H asked her to go to the office to administer the medications. While walking to the office, R8 pointed to a pill that was on the floor and informed ULP-H she had dropped it. ULP-H picked up the pill, counted the pills in the cup, and then placed the pill back into the medication cup and proceeded to administer the medications to R8.	0 510		

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0 510	Continued From page 9 ULP-H's employee file lacked evidence training and competencies for medication administration had been completed by a registered nurse (RN). On June 27, 2023, at 1:57 p.m. RN-B stated ULP-H should not have administered a pill that was picked up off the floor. Instead she should have identified the pill, retrieved a new pill from the medication card and administered the new pill. Further, staff should not punch medications out into their hand, they should punch them out directly into the medication cup. The licensee's undated, Administration of Medication by Unlicensed Personnel policy identified "Unlicensed personnel that will provide assistance with medication administration will be trained and competency tested by the RN" included "Infection control precautions that must be followed when administering medications". The licensee's undated, Administration of Oral Medications policy identified "When administering oral medications, open the dosage box to the correct day and time and pour the medications into the client's hand or medication cup. Do not touch the pills with your hands." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 640		

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0 640	Continued From page 10 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, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 a facility tour on June 26, 2023, at 12:30 p.m., with registered nurse (RN)-C, there was no visible posting for information and phone numbers for reporting to the MAARC or the 911	0 640		

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0 640	Continued From page 11 emergency number. RN-C stated it was not posted, but it should be. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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. In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB)	0 660		

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0 660	Continued From page 12 screening such as a blood test for two of two unlicensed personnel (ULP-D, ULP-H). 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: RISK ASSESSMENT The licensees TB risk assessment dated April 2021, indicated the licensee was at low risk. On June 26, 2023, at 1:55 p.m. registered nurse (RN)-B indicated the facility TB risk assessment had not been completed since 2021, and she was going to work on it. ULP-D ULP-D began providing direct care services for the licensee on May 18, 2023. ULP-D's employee record identified a TB screening tool dated May 3, 2023; however, the document was blank. On June 29, 2023, at 2:00 p.m. human resources manager (HRM)-L confirmed ULP-D's file did not contain evidence a TB test or TB symptom screen was completed at the time of hire. ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022.	0 660		

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0 660	Continued From page 13 ULP-H's employee record identified a TB symptom screening completed on May 20, 2022; however, the record lacked evidence TB testing had been completed. On June 28, 2023, at 1:05 p.m. RN-B stated there was no proof of TB testing in ULP-H's file. The licensee's TB Prevention and Control policy dated January 2014, indicated the RN would complete an annual review and revision of the TB risk assessment and the licensee would be responsible for staff screening as well as maintenance of all TB screening reports in the personnel files. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff 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	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 14 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 an emergency preparedness plan prominently and failed to conduct two full scale drills in the last year. 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). The findings include: During a facility tour on June 26, 2023, at 12:30 p.m., with registered nurse (RN)-C, the surveyor observed no signage posted or information regarding the licensee's emergency plan. RN-C stated the emergency preparedness was not displayed for the public. The emergency preparedness binders were kept in the offices and were not accessible to residents or visitors.	0 680		

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	32647	A. BUILDING: _____ B. WING _____	06/30/2023

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0 680	Continued From page 15 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 16 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide the required training frequency for employees and residents on fire safety and evacuation; and failed to meet the evacuation drill frequency requirements. This deficient condition 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) 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). Findings include: On June 27, 2023, between 1:00 p.m. and 3:15 p.m., survey staff toured the facility with the director of environmental services (DES)-G and maintenance (M)-F. During the facility tour, survey staff observed that that posted evacuation maps did not identify the location and number of resident sleeping rooms for the assisted living wing. On June 27, 2023, at approximately 3:15 p.m., records were provided for review. Records were reviewed by survey staff on June 27, 2023, between 3:15 p.m. and 4:15 p.m.	0 810		

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0 810	Continued From page 17 Record review of the fire safety and evacuation plans indicated that the licensee had not identified the location and number of resident sleeping rooms for the assisted living wing. Record review of the available documentation did not support that the employee training frequency on the fire safety and evacuation plans had been completed upon hire and at least twice per year thereafter. No employee training records were provided. Record review of the available documentation did not support that resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had been completed annually. No resident training records were provided. Record review of documented evacuation drills indicated that an evacuation drill for employees had been completed on 05-24-2023 during the day shift. No additional evacuation drill records were provided. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On June 27, 2023, at approximately 4:30 p.m., maintenance (M)-F verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 18 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On June 27, 2023, between 1:00 p.m. and 3:15 p.m., survey staff toured the facility with the director of environmental services (DES)-G and maintenance (M)-F. During the facility tour, survey staff observed a space heater in a dementia care resident's sleeping room in unit 1169.	0 820		

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0 820	Continued From page 19 This deficient condition was verified by DES-G and M-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of four resident's (R2, R3, R4) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on September 25, 2020, with a diagnosis including dementia. R2's service plan dated September 22, 2022, included assistance with medication management, bathing, dressing, toileting, and transfers. R2's contract dated August 4, 2021, included on page 21, a designated representative form that was not on a separate form and did not include the required language. R3 R3 was admitted on October 19, 2022, with diagnoses including unspecified dementia and	0 950		

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0 950	Continued From page 21 epilepsy. R3's service plan dated January 4, 2023, included assistance with medication management, bathing, dressing, toileting, and transfers. R3's record showed no evidence of the required designated representative language. R4 R4 was admitted on June 13, 2022, with a diagnosis of Alzheimer's disease. R4's Service and Payment Agreement dated June 8, 2022, contained numerous support packages a resident could receive; however, it failed to identify the services R4 was to receive. R4's care plan, unsigned and undated, identified R4 received blood glucose testing, medication administration, bathing, dressing and grooming. R4's contract dated July 18, 2022, failed to include a separate form for the designated representative, and it did not include the required language. The licensee's admission's packet contained two different versions of the designated representative form; neither contained the required language. On June 29, 2023, at 2:00 p.m. the director of sales and marketing (DSM)-N stated the current admissions packet containing the blank contract did not contain the required language about the designated representative. No further information was provided.	0 950		

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0 950	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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 observation, interview and record review, the licensee failed to ensure a background study was completed and cleared prior to staff providing services for one of five employees (unlicensed personnel (ULP)-J). This had the potential to affect all residents. This resulted in an immediate correction order on June 27, 2023, at 4:32 p.m. In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (ULP-H, ULP-I, licensed practical nurse (LPN)-K). This practice resulted in a level three violation (a	01290		

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01290	Continued From page 23 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: ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5 without direct supervision. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6 without direct supervision. According to Department of Human Services NETStudy for background studies, ULP-J was not cleared to provide direct care services to residents without direct supervision. On June 27, 2023, at 5:04 p.m. regional human resources stated the NETStudy showed ULP-J did not have a current active background study. She was unaware the employees needed to be affiliated with each licensee they worked for. The licensee's Recruiting & Onboarding dated July 1, 2012, identified "Applicants for employment with facilities owned or managed by [the licensee], and it's subsidiaries, will receive job offers contingent upon the satisfactory	01290		

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01290	Continued From page 24 completion of a background screening" No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three employees (ULP-H, ULP-I, LPN-K). ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered liquid and other oral medications to R7. - at 7:35 a.m., ULP-H administered oral medications for R8. - at 7:58 a.m., ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee record contained a background study dated February 2, 2022, affiliated with a separate location operated by the licensee's owner under HFID license 25044. ULP-H's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living with dementia care HFID license 32647, effective August 1, 2021. ULP-I ULP-I began providing services under the ALFDC	01290		

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01290	Continued From page 25 license on December 27, 2022. On June 27, 2023, ULP-I was observed completing the following: - at 8:15 a.m., administered medication to R2. - at 9:15 a.m. assisted with dressing and toileting to R2. ULP-I's employee record contained a background study dated August 15, 2019, affiliated with a separate location operated by the licensee's owner under HFID license 25044. ULP-I's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living with dementia care HFID license 32647, effective August 1, 2021. LPN-K began providing services under the ALFDC license on September 28, 2022. LPN-K's employee record contained a background study dated December 8, 2015, affiliated with a separate location operated by the licensee's owner under HFID license 25044. LPN-K's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living with dementia care HFID license 32647, effective August 1, 2021. On June 28, 2023, at 10:14 a.m., the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01290		

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01290	Continued From page 26 days	01290		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure orientation to assisted living licensing and requirements was completed for one of one agency staff (unlicensed personnel (ULP)-P) prior to providing services for 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-P was an agency staff and started working for the licensee on June 26, 2023. No employee record was found. Staffing schedule for the week of June 26, 2023, through June 30, 2023, shows ULP-P working both morning and afternoon shifts in the memory care unit. On June 26, 2023, at 3:30 p.m. ULP- P stated	01350		

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01350	Continued From page 27 she started today and came an hour before the shift started and followed another agency employee. ULP-P stated she had no training and no "cheat sheet" for the residents like some facilities provided. On June 30, 2023, at 2:00 p.m. human resources manager (HRM)-L confirmed ULP-P was not trained, and an employee file had not been created for her yet. The licensee's Supervision of Licensed and Unlicensed Personnel Policy, last updated April 2018, indicated staff from a temporary staffing agency will be supervised according to the procedure that applies to the type of services they are providing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01350		
01360 SS=D	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse.	01360		

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01360	Continued From page 28 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 for one of three unlicensed personnel (ULP-J) providing assisted living services were conducted by a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J's employee record identified ULP-J had completed competencies for medication administration with licensed practical nurse (LPN)-Q. There was no evidence a RN provided the training or competencies, or had provided oversight to LPN-Q for the medication	01360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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
01360	Continued From page 29 administration competencies. ULP-J lacked an employee record with evidence the employee had been trained by a RN in the following areas: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; - training on the prevention of falls; - 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; - 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; awareness of confidentiality and privacy; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01360		

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01360	Continued From page 30 appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required On June 28, 2023, at 9:05 a.m. RN-B stated ULP-J was an internal float for the company with other licensees. There was no further training or competency testing found for ULP-J and there were no records identifying ULP-J had been trained and deemed competent by a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
01370 SS=D	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	01370		

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01370	Continued From page 31 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; (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 two of three unlicensed personnel (ULP-D, ULP-H) completed training and competency evaluations in all required training topics. 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	01370		

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01370	Continued From page 32 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D began providing direct care services for the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed completing the following: - at 8:03 a.m., assisted residents with breakfast and eating assistance. - at 8:38 a.m., assisted R2 with dressing and transfers. ULP-D's employee record lacked evidence of training and competency for the following topics. -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -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 (iv) dressing and assisting with toileting -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -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;	01370		

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01370	Continued From page 33 -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking for the ULP staff. On June 29, 2023, at 2:30 p.m. human resources director (HRD)-M stated ULP-D's record lacked the required training. ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered liquid and other oral medications to R7; - at 7:35 a.m., ULP-H administered oral medications for R8; - at 7:58 a.m., ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee file lacked evidence medication, exercise, and treatment reminders training had been completed by a RN. On June 28, 2023, at 9:05 a.m. RN-B stated there was no further training for ULP-H and there were no records identifying ULP-H had been trained in the above topics as required.	01370		

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01370	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	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, 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 two of three unlicensed personnel (ULP-D, and ULP-H) completed training and competency evaluations in all required training topics. 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	01380		

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01380	Continued From page 35 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D began providing direct care services for the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed completing the following: - at 8:03 a.m., assisted residents with breakfast and eating assistance; - at 8:38 a.m., assisted R2 with dressing and transfers. ULP-D's employee record lacked evidence of training and competency for the following topics: - Observing, reporting, and documenting resident care; - Safe transfer techniques and ambulation; and - Range of motioning and positioning On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking for the ULP staff. On June 29, 2023, at 2:30 p.m. the human resources manager (HRM)-L stated ULP-D's file lacked evidence of the required training. ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022.	01380		

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01380	Continued From page 36 On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered R7's oral medications; - at 7:35 a.m., ULP-H administered R8's oral medications; - at 7:58 a.m., ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee file lacked evidence the following training and/or competency evaluations had been completed: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - administering medications or treatments as required. On June 28, 2023, at 9:05 a.m. RN-B stated there was no further training for ULP-H and there were no records identifying ULP-H had been trained and/or had competency testing in the above topics as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=E	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	01440		

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01440	Continued From page 37 registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff 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 a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of three unlicensed personnel (ULP-H, ULP-J, and 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).	01440		

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01440	Continued From page 38 The findings include: ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered R7's oral medications; - at 7:35 a.m., ULP-H administered R8's oral medications; and - at 7:58 a.m., ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee file lacked evidence a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services. ULP-J ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J's employee file lacked evidence a RN conducted direct supervision of staff performing a delegated task within 30 days of providing services.	01440		

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01440	Continued From page 39 On June 28, 2023, at 9:05 a.m. RN-B stated there was no further information for ULP-H and ULP-J; therefore, if it was not in the employee file it was not done. ULP-D ULP-D began providing services under the Assisted Living with Dementia Care (ALFDC) license on May 18, 2023. On June 27, 2023, ULP-D was observed completing the following: -8:03 a.m., assisted residents with breakfast and eating assistance; and -8:38 a.m., assisted R2 with dressing and transfers for R2. ULP-D's employee file lacked evidence a RN conducted direct supervision of staff performing a delegated task within 30 days of providing services. On June 28, 2023, at 8:00 a.m. RN-B stated ULP-D's record lacked evidence of supervision of a delegated task within 30 days. The licensee's Supervision of Licensed and Unlicensed Personnel policy undated, identified "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following 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	01470		

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01470	Continued From page 41 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 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 three of three unlicensed personnel (ULP-D, ULP-H, and ULP-J) received orientation to include the required content. 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-D ULP-D began providing direct care services for	01470		

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01470	Continued From page 42 the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed completing the following: - at 8:03 a.m., assisted residents with breakfast and eating assistance. - at 8:38 a.m., assisted R2 with dressing and transfers. ULP-D's employee record lacked evidence of orientation for the following topics: - an overview of this chapter. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - 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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure -orientation to each specific resident and services provided. On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking as indicated above. On June 29, 2023, at 2:30 p.m. human resources manager (HRM)-L stated ULP-D's file lacked evidence of the required training.	01470		

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01470	Continued From page 43 ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered R7's oral medications; - at 7:35 a.m. ULP-H administered R8's oral medications; and - at 7:58 a.m. ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee record lacked evidence of orientation for the following 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; (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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.	01470		

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01470	Continued From page 44 ULP-J ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J's employee file lacked evidence of orientation for the following 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; (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	01470		

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01470	Continued From page 45 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking as indicated above. The licensee's Orientation for New Employees policy dated May 11, 2017, failed to identify the required orientation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents 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) and was issued at an isolated scope (when one or a limited number of	01480		

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01480	Continued From page 46 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D began providing direct care services for the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed training a new employee who was shadowing her for the day. ULP-D was observed completing the following: - at 8:03 a.m., assisted residents with breakfast and eating assistance; and - at 8:38 a.m., assisted R2 with dressing and transfers. ULP-D's employee record lacked evidence of orientation to each specific resident and services provided. On June 27, 2023, at 9:10 a.m. ULP-D stated she had been working for the licensee for one month and has never been trained on this floor. ULP-D did not know the residents' cares or their names, and was expected to train another ULP today. On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking as indicated above. On June 29, 2023, at 2:30 p.m. human resources manager (HRM)-L stated ULP-D's file lacked evidence of the required training. The licensee's Orientation for New Employees policy dated May 11. 2017, indicated the employee is oriented to the department with emphasis on specific job duties, fire and safety	01480		

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01480	Continued From page 47 prevention, disaster procedures and infection control including universal precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01480		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual 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 48 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 received at least eight hours of annual training for each 12 months of employment and training failed to include all required topics for one of one unlicensed personnel (ULP-H). 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 49 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m., ULP-H administered R7's oral medications; - at 7:35 a.m., ULP-H administered R8's oral medications; - at 7:58 a.m., ULP-H completed R4's blood glucose monitoring and administered insulin to R4. ULP-H's employee record indicated ULP-H had completed 4.75 hours of training in the last 12 months, and lacked evidence of annual training in the following required topics: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 50 On June 28, 2023, at 8:00 a.m. registered nurse (RN)-B stated training was lacking as indicated above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not 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 three unlicensed personnel (ULP-J and ULP-D) received the required amount of dementia care training.	01540		

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01540	Continued From page 51 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J state she had been working for the licensee full time since February 2023. ULP-J's record identified she completed the following: - Alzheimer's Disease and Related Disorders: An Overview on April 16, 2023; - Dementia Care: Ethical Considerations on February 27, 2023; and - Ethics and the Care of Persons Living with Dementia on April 16, 2023; The dementia education completed was a total of three hours, and not eight hours as required. On June 28, 2023, at 9:05 a.m. RN-B stated there	01540		

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01540	Continued From page 52 was no further information for ULP-J; therefore, if it was not in the employee file, it was not done. ULP-D ULP-D began providing direct care services for the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed working in a secured memory care unit completing the following: - at 8:03 a.m., assisted with breakfast and eating assistance; - at 8:38 a.m., assisted R2 with dressing and transfers. On June 27, 2023, at 9:10 a.m. ULP-D stated she had worked for the licensee for one month and had not been trained. ULP-D's employee record identified completion of one on-line dementia training class totaling 30 minutes: - Dementia Care: Ethical Considerations on May 18, 2023. On June 29, 2023, at 2:30 p.m. human resources manager (HRM)-L stated ULP-D's file lacked evidence of the required training. The licensee's Dementia Training Program Disclosure - Assisted Living with Dementia Care Licensure policy undated, identified "Training Topic Requirements for All New Hire Staff 1) An explanation of Alzheimer's Disease and other dementia's; 2) Assistance with activities of daily living; 3) Problem solving with challenging behaviors; 4) Communications skills; 5) Person-centered planning and service delivery;	01540		

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01540	Continued From page 53 6) Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and 7) Standards of dementia care including non-pharmacological dementia care practices that are person-centered and evidence-informed". For direct care staff "At least eight hours of training that includes the topics listed above. The training must be completed within 80 working hours of employment start date". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01560 SS=D	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: (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:	01560		

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01560	Continued From page 54 Based on observation, interview and record review, the licensee failed to ensure two of three unlicensed personnel (ULP-J and ULP-D) received dementia care training in all required topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-J ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J's record identified she completed the following: - Alzheimer's Disease and Related Disorders: An Overview on April 16, 2023; - Dementia Care: Ethical Considerations on February 27, 2023; and - Ethics and the Care of Persons Living with Dementia on April 16, 2023.	01560		

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01560	Continued From page 55 ULP-J's record lacked evidence she had completed training in the following required topics: - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On June 28, 2023, at 9:05 a.m. RN-B stated there was no further information for ULP-J; therefore, if it was not in the employee file, it was not done. ULP-D ULP-D began providing direct care services for the licensee on May 18, 2023. On June 27, 2023, ULP-D was observed working in a secured memory care unit completing the following: - at 8:03 a.m., assisted with breakfast and eating assistance; and - at 8:38 a.m., assisted R2 with dressing and transfers. ULP-D's employee record identified completion of one on-line dementia training class totaling 30 minutes: - Dementia Care: Ethical Considerations on May 18, 2023. ULP-D's record lacked evidence of completed training in the following required topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery.	01560		

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01560	Continued From page 56 On June 29, 2023, at 2:30 p.m. the human resources manager (HRM)-L stated ULP-D's file lacked evidence of the required dementia training. The licensee's Dementia Training Program Disclosure - Assisted Living with Dementia Care Licensure policy undated, identified "Training Topic Requirements for All New Hire Staff 1) An explanation of Alzheimer's Disease and other dementia's; 2) Assistance with activities of daily living; 3) Problem solving with challenging behaviors; 4) Communications skills; 5) Person-centered planning and service delivery; 6) Understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and 7) Standards of dementia care including non-pharmacological dementia care practices that are person-centered and evidence-informed". For direct care staff "At least eight hours of training that includes the topics listed above. The training must be completed within 80 working hours of employment start date". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 57 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 a change in condition assessment was completed for one of one resident (R4) in addition, the licensee failed to ensure a reassessment not to exceed 90 days was completed 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) 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:	01620		

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	32647	A. BUILDING: _____ B. WING _____	06/30/2023

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01620	Continued From page 58 R4 was admitted on June 13, 2022, with a diagnosis including Alzheimer's disease. R4's Service and Payment Agreement dated June 8, 2022, contained numerous support packages a resident could receive, however, it failed to identify the services R4 was to receive. R4's care plan, unsigned and undated, identified R4 received blood glucose testing, medication administration, bathing, dressing and grooming. R4's record included Consent for Hospice Election and Benefit form dated November 15, 2022. R4's Fall's Flow Sheet dated June 16, 2023, identified R4 had a fall when reaching for his remote. R4's incident report included an illegible date, identified "On call nurse notified of resident falling. He was looking for the remote for his TV and fell over. On call nurse called, vitals take, assessed for injury, assisted back up. No Injuries observed at time of incident." There was no further information completed on the form. R4's record identified 90-day comprehensive assessments completed on December 1, 2023, February 8, 2023, and April 27, 2023. R4's record failed to identify a change in condition assessment was completed when R4 was admitted to hospice services on November 15, 2022. In addition, R4's record lacked evidence an assessment was completed by a registered nurse (RN) after a fall to determine if a significant change in condition had occurred or to implement changes to care if needed.	01620		

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01620	Continued From page 59 On June 29, 2023, at 2:04 p.m. RN-B stated there was no assessment completed when R4 was admitted to hospice and there were no assessments completed after R4 fell. A change in condition assessment should have been completed when R4 went on hospice care as that would be a change in condition. RN-B further stated a follow up post fall assessment was not completed. The report was a data collection, but not an assessment. There should be a post fall assessment completed after any fall to determine if there are any interventions needed to prevent further falls and determine if there was a change in condition. R2 R2 was admitted on September 25, 2020, with a diagnosis of dementia. R2's service plan dated September 22, 2022, indicated resident received assistance with medication management, bathing, dressing, toileting, and transfers. R2's record indicated a comprehensive 90-day assessment was completed on December 15, 2022, and March 13, 2023. There were no other assessments after that date. On June 28, 2023, at 1:00 p.m. RN-B confirmed R2's record lacked a current assessment and the last assessment completed was March 13, 2023. RN-B stated "the nursing staff have admitted to me that assessments are behind." The licensee's nuptial and Ongoing Resident Evaluations and Assessments policy dated August 1, 2021, identified "A Registered Nurse will complete the following nursing assessments	01620		

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01620	Continued From page 60 using the Uniform Assessment Tool: a. Pre-Admission Assessment of the prospective resident; bi 14-day assessment: completed up to 14-days after start of services; c. Resident reassessment and monitoring: completed periodically but no less than every 90-days; or. d. Change in resident condition". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	01650		

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01650	Continued From page 61 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R4, R5). 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: R4 R4 was admitted on June 13, 2022, with diagnoses including Alzheimer's diabetes, depression, pain related to cancer, and anxiety. On June 27, 2023, at 7:58 a.m. ULP-H was observed checking R4's blood glucose and administering insulin to R4. R4's Service and Payment Agreement dated June 8, 2022, contained numerous support packages a resident could receive; however, it failed to	01650		

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01650	Continued From page 62 identify which package R4 received. It failed to include the following required information: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R4's Service and Payment Agreement identified Individualized Initial Assessment will be conducted in person by RN and will be completed within five days after initiation of home care services, instead of the required time frame of prior to the date the resident executes a contract with the facility or on the date the resident moves in. R4's care plan, unsigned and undated, identified R4 receives services including blood glucose testing, medication administration, bathing, dressing and grooming. It included the following statement: "Assessment within five days of initiation of	01650		

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01650	Continued From page 63 Assisted Living services and a nurse visit for monitoring and reassessment within 14 days of the date Assisted Living services were initiated, instead of the required time frame of prior to the date the resident executes a contract with the facility, or on the date the resident moves in." R5 R5 was admitted on February 19, 2019, to the comprehensive home care license and the assisted living license on August 1, 2021. R5 had diagnoses including depression, anxiety, chronic kidney disease, age related cognitive decline, dementia, and diabetes. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5. R5's care plan, identified as the service plan, dated June 23, 2023, failed to identify: - the fees for services. On June 29, 2023, at 9:14 a.m. registered nurse (RN)-B stated if there was no signature on the care plan provided, then it was not signed. The care plan should have been signed by the nurse and resident representative. For R4, the only signed document was the Service and Payment Agreement; therefore, there was no evidence the care plan had been provided to the resident or responsible party. The licensee's Admission Process for New Clients policy, undated, identified "Service Plan. Upon completion of the individualized initial nursing assessment, the RN develops a service plan with the client and/or the client's representative no more than 14 days after the initiation of home care services. The service	01650		

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01650	Continued From page 64 plan/care plan includes: a description of the home care services to be provided, the fees for services, and the frequency of each service according to the client's current review or assessment and the client's preferences; identification of staff or categories of staff who will provide the services, the assessment schedule or monitoring reviews(14 day, 90 day, as needed based on the change in condition), and the methods (in person-at the client's residence, or via phone); the frequency (within 30 days of hire), The RN will provide a supervisory visit of unlicensed personnel as well as on an as needed basis; and a contingency plan that includes: the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; information and method for a client or client's representative to contact the home care provider; names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in client's condition, including identification as to who has authority to sign for the client in an emergency; and the circumstances in which emergency medical services are not to be summoned consistent with chapters 1458 and 145C; and declarations made by the client under those chapters. The RN and the client and/or the client's representative sign the service plan/care plan, and the RN gives a copy of the service plan/care plan to the client and/or the client's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		

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01750	Continued From page 65	01750		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-H) completed training and competency evaluations for medication administration. This had the potential to affect all residents receiving medication administration. This resulted in an immediate correction order identified on June 28, 2023, at 9:05 a.m. In addition, the licensee failed to ensure a registered nurse completed medication training and competency evaluations for one of three employees (ULP-J) 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	01750		

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01750	Continued From page 66 portion or all of the residents). The findings include: ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, ULP-H was observed completing the following: - at 7:18 a.m. ULP-H administered liquid and other oral medications to R7. While preparing the medication, she punched the meds into her ungloved hand and then placed them into the medication cup; - at 7:35 a.m. ULP-H set up medications for R8. R8 was in the dining room and ULP-H asked her to go to the office to administer the medications. While walking to the office, R8 pointed to a pill that was on the floor and informed ULP-H she had dropped it. ULP-H picked up the pill, counted the pills in the cup, and then placed the pill back into the medication cup and proceeded to administer the medications to R8; - at 7:58 a.m. ULP-H completed R4's blood glucose monitoring with a result of 131. R4 stated he did not want to get out of bed for breakfast until 9:00 a.m. or 10:00 a.m. ULP-H proceeded to administer Lantus insulin (long acting insulin) 31 units and administered Novolog (short acting insulin) 13 units. ULP-H stated she would hold R4's room tray and administer the rest of R4's medications later; - at 10:21 a.m. the surveyor asked ULP-H if R4 had eaten breakfast yet and ULP-H stated he had not, so she would go check on him. R4 agreed to get up and have breakfast at that time. ULP-H heated R4's breakfast tray and brought it to his room. R4 went to the table in his room and started to eat.	01750		

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01750	Continued From page 67 R4's medication administration record dated June 7, 2023, through June 28, 2023, identified "Novolog solution 100 unit/ml (insulin aspart) Inject 13 units subcutaneously three times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Inject 13 Units under the skin 3 (three) times a day **WITH MEALS**. **HOLD IF BLOOD SURGAR (sp) IS LESS THAN 150** **HOLD IF NOT EATING**" ULP-H's employee file lacked evidence training and competencies for medication administration had been completed by a registered nurse (RN). On June 27, 2023, at 1:57 p.m. RN-B stated ULP-H should not have administered a pill that was picked up off the floor. Instead she should have identified the pill, retrieved a new pill from the medication card and administered the new pill. Further, staff should not punch medications out into their hand, they should punch them out directly into the medication cup. In addition, ULP-H should not have administered insulin until R4 was ready to get up and eat breakfast. Insulin should never be given until a resident is on their way to the meal to prevent them from becoming hypoglycemic (low blood sugar). The licensee failed to ensure a registered nurse completed medication training and competency evaluations for one of three employees (ULP-J) ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose and administering insulin to R5.	01750		

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01750	Continued From page 68 On June 27, 2023, at 10:03 a.m. ULP-J was observed administering oral medications and eye drops to R6. ULP-J's employee record identified ULP-J had completed competencies for medication administration with licensed practical nurse (LPN)-Q. There was no evidence a RN provided the training or competencies, or had provided oversight to LPN-Q for the medication administration competencies. On June 28, 2023, at 9:05 a.m. RN-B stated there was no further training for ULP-H and there were no records identifying ULP-H had been trained and deemed competent by a RN to administer medications. At 11:20 a.m., RN-B further stated the Novolog order identified to hold the insulin if blood sugar was below 150. If the blood sugar was 131, Novolog should not have been administered, and if R4 was not eating, Novolog should not have been administered. The physician orders were not followed. RN-B stated ULP-J was an internal float for the company with other licensees. There was no further training or competency testing found for ULP-J and there were no records identifying ULP-J had been trained and competency evaluations were completed by an RN. Novolog prescribing information dated December 2012, identified Novolog should be given immediately (within 5-10 minutes) prior to the start of a meal. The licensee's Delegation of Nursing Tasks, Medication Administration, Treatment Administration or Therapy Tasks to Unlicensed Personnel dated August 1, 2021, identified	01750		

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01750	Continued From page 69 "Unlicensed personnel (ULP) may perform nursing task or activities, including medication administration, treatment administration or therapy tasks, beyond their usual and customary roles if delegated by the Registered Nurse (RN). Delegation occurs when the RN transfers the responsibility for the performance of a nursing task or activity in a specific situation to another nursing staff member who is competent and possess the knowledge and skills to perform the task, while the RN retains the accountability for the outcome. Using his/her professional judgment, the RN may delegate nursing tasks or activities to an LPN or ULP." The licensee's undated, Training Unlicensed Personnel for Medications Administration policy, identified, "Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, the RN must instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. "The RN will instruct and competency test the unlicensed personnel on the following topics and tasks before delegating to them the task of medication administration or assistance with self-administration of medications: a. The 6 RIGHTS of medication b. Infection control techniques that must be followed when administering medications, including hand washing and the use of gloves when appropriate. c. The complete procedure for checking a client's medication record and the nurse's written procedures specific to the client for the administration of any medications being managed by our agency. This includes procedures for administration of any over-the-counter medications, PRN medications or dietary	01750		

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01750	Continued From page 70 supplements our agency has agreed to manage for the client.. d. The preparation of the medication for administration. e. Procedures for the proper methods to administer the various medications to the client. f. How to document medication management services provided for the client consistent with our agency's MAR documentation procedure. 8. The type of information reportable to a nurse regarding assistance or administration of medications, including side effects, effectiveness of the medication, refused or held medications and medication errors." "The RN must have communicated with unlicensed personnel about the individual needs of the client prior to the delegation of medication administration to the unlicensed personnel. This communication will be in written and/or verbal form." "The RN will document the training and competency of unlicensed personnel to properly administer each type of medication they are assigned to administer in the staff person's personnel record and in the ([electronic training program]) that identifies which unlicensed personnel are competent to administer various types of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 29, 2023, at 9:28 a.m., the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of l.	01750		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 71	01760		
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 mediations were administered as prescribed for one of ten residents (R4) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 27, 2023, ULP-H was observed completing the following: - at 7:58 a.m., ULP-H completed R4's blood	01760		

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	32647	A. BUILDING: _____ B. WING _____	06/30/2023

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01760	Continued From page 72 glucose monitoring with a result of 131. R4 stated he did not want to get out of bed for breakfast until 9:00 a.m. or 10:00 a.m. ULP-H proceeded to administer Lantus insulin (long-acting insulin) 31 units and administered Novolog (short-acting insulin) 13 units. ULP-H stated she would hold R4's room tray and administer the rest of R4's medications later; - at 10:21 a.m., the surveyor asked ULP-H if R4 had eaten breakfast yet and ULP-H stated he had not, so she would go check on him. R4 agreed to get up and have breakfast at that time. ULP-H heated R4's breakfast tray and brought it to his room. R4 went to the table in his room and started to eat. R4's medication administration record dated June 7, 2023, through June 28, 2023, identified "Novolog solution 100 unit/ml (insulin aspart) Inject 13 units subcutaneously three times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Inject 13 Units under the skin 3 (three) times a day **WITH MEALS**. **HOLD IF BLOOD SURGAR (sp) IS LESS THAN 150** **HOLD IF NOT EATING**" R4's physician orders dated June 9, 2023, identified Novolog insulin inject 13 units under the skin three times a day with meals. Hold if not eating or if blood sugar is less then 150. On June 27, 2023, at 1:57 p.m. RN-B stated ULP-H should not have administered insulin until R4 was ready to get up and eat breakfast. Insulin should never be given until a resident is on their way to the meal to prevent them from becoming hypoglycemic (low blood sugar). Novolog prescribing information dated December	01760		

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01760	Continued From page 73 2012, identified Novolog should be given immediately (within 5-10 minutes) prior to the start of a meal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for one of one resident (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 27, 2023, at 7:35 a.m. ULP-H was observed administering oral medications to R8.	01770		

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01770	Continued From page 74 R8's undated and unsigned, care plan identified as the service plan, indicated R8's medications were set up by the nurse. On June 29, 2023, at 9:14 a.m. registered nurse (RN)-B stated medications set up by a nurse were set up into the bubble packs. There was no documentation in R8's record of medication set up. The licensee's Medication Management Services policy dated March 11, 2022, identified "Medication Set Up. When setting up medication for later administration the RN or LPN will: a. Verify that the dose and quantity of medications delivered is consistent with the prescription; b. Review prescribed medications to identify any contraindications or other concerns; c. Identify whether refills are needed and follow up to be sure the refill is available when needed;and d. Verify that medications for the previous period were administered as prescribed. If the nurse identifies any discrepancies or concerns when setting up medications, the nurse will complete appropriate follow up and documentation of the results of the follow up." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 75 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for two of two residents (R4 and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 27, 2023, at 7:42 a.m. review of R4's insulin pens with unlicensed personnel (ULP)-H identified the following: Three Lantus insulin (long-acting) pens opened and in use: - one pen had 8 units of insulin remaining, and there were no open or expiration dates on it; - one pen with no open or expiration dates on it; and - one pen had an open date of June 20, 2023. One Novolog insulin (short-acting) pen in use. It had no open or expiration dates on the pen. ULP-H stated they should be labeled when opened.	01890		

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01890	Continued From page 76 On June 27, 2023, at 8:26 a.m. a review of R5's insulin pens with ULP-J identified a Humulin insulin (short-acting) pen, which included the date opened identified as the number six and the expiration date was written as December 29, 2023. ULP-J stated she did not know how long insulin was good for after it was opened. On June 27, 2023, at 9:26 a.m. registered nurse (RN)-B stated all insulin pens should be dated when they are opened and staff should be aware of how long it is good for after it is opened. There should not be more then one insulin pen open and in use at one time. Lantus Solostar prescribing information dated November 2018, identified "Once you take your Solostar out of cool storage for use, or as a spare, you can use it for up to 28 days." Novolog prescribing information dated December 2012, identified "The Novolog FlexTouch pen you are using should be thrown away after 28 days, even if it has insulin left in it. Humulin Kwikpen prescribing information dated November 2018, identified "Throw away the HUMULIN N Pen you are using after 14 days, even if it still has insulin left in it." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910		

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01910	Continued From page 77 resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included atrial fibrillation	01910		

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01910	Continued From page 78 (abnormal heartbeat), hypothyroidism, and Alzheimer's disease. R1's discharge plan indicated the following medications were sent with the resident: Levothyroxine 75 mcg (microgram) - 21 tablets (thyroid medication) Metoprolol 50 mg (milligram) - 22.5 tablets (used for high blood pressure) Rosuvastatin 10 mg - 23 tablets (lowers cholesterol) Eliquis 2.5 mg 46 tablets (prevents blood clots) Vitamin D3 50 mcg - 23 tablets Tylenol 500 mg - 30 tablets Donepezil 10 mg - 23 tablets R1's discharge notes dated May 31, 2023, included the name of the medication, the dosage and number of tablets and all medications were sent with R1's daughter. R1's discharge plan failed to include the prescription number as required. On January 31, 2023, at 9:08 a.m. licensed assisted living director (LALD)-A stated R1's record lacked the required content for the disposition of medications noted above. The licensee's medication management service policy, undated, indicated the RN is responsible for the disposal of unused medications. The policy did not indicate the process for proper documentation of unused medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01950	Continued From page 79	01950		
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 two of two unlicensed personnel (ULP-H and ULP-J) completed training and competency evaluations for blood glucose testing. 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	01950		

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01950	Continued From page 80 situation has occurred only occasionally). The findings include: ULP-H ULP-H began providing services under the Assisted Living with Dementia Care (ALFDC) license on February 2, 2022. On June 27, 2023, at 7:58 a.m. ULP-H was observed checking R4's blood glucose monitoring. ULP-H's employee file lacked evidence training and competencies for blood glucose monitoring had been completed by a registered nurse (RN). ULP-J ULP-J began providing services under the Assisted Living with Dementia Care license on February 24, 2023. On June 27, 2023, at 8:45 a.m. ULP-J was observed checking blood glucose for R5. ULP-J's employee record identified ULP-J had completed competencies for blood glucose monitoring with licensed practical nurse (LPN)-Q. There was no evidence a RN provided the training or competencies, or had provided oversight to LPN-Q for the blood glucose monitoring. On June 28, 2023, at 9:05 a.m. RN-B stated there was no further training for ULP-H and there were no records identifying ULP-H had been trained and deemed competent by a RN to blood glucose monitoring. RN-B stated ULP-J was an internal float for the company with other licensees. There	01950		

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01950	Continued From page 81 was no further training or competency testing found for ULP-J and there were no records identifying ULP-J had been trained and competency evaluations were completed by an RN. The licensee's Delegation of Nursing Tasks, Medication Administration, Treatment Administration or Therapy Tasks to Unlicensed Personnel dated August 1, 2021, identified "Unlicensed personnel (ULP) may perform nursing task or activities, including medication administration, treatment administration or therapy tasks, beyond their usual and customary roles if delegated by the Registered Nurse (RN). Delegation occurs when the RN transfers the responsibility for the performance of a nursing task or activity in a specific situation to another nursing staff member who is competent and possess the knowledge and skills to perform the task, while the RN retains the accountability for the outcome. Using his/her professional judgment, the RN may delegate nursing tasks or activities to an LPN or ULP." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or	01970		

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01970	Continued From page 82 therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written prescriber's order for blood glucose monitoring was obtained for one of two residents (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) 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: R4 was admitted on June 13, 2022, with diagnoses including Alzheimer's disease, diabetes, depression, pain related to cancer, and anxiety. On June 27, 2023, at 7:58 a.m. ULP-H was observed checking R4's blood glucose and administering insulin to R4. R4's physician orders dated May, 25, 2023, identified as the current orders, lacked an order for blood glucose monitoring. R4's medical record lacked evidence of a prescriber's order for blood glucose monitoring. On June 27, 2023, at 7:58 a.m. ULP-H completed R4's blood glucose monitoring.	01970		

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01970	Continued From page 83 R4's medication administration record dated June 7, 2023, through June 28, 2023, identified blood glucose monitoring was completed four times per day. On June 29, 2023, at 1:08 p.m. registered nurse (RN)-B stated the most current and complete orders were the ones provided to the surveyor. The licensee's Development of the Treatment and Therapy Services and Individualized Treatment and Therapy Record policy dated August 1, 2021, identified "1. The RN will develop and individualized treatment and/or therapy management plan for those receiving ordered or prescribed treatment and therapies. 2. The type of services that will be provided will be recorded in Point Click Care (PCC) 3. The plan will include: a. A statement of the services that will be provided; b. Documentation of specific resident instructions relating to treatments or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and e. Any resident - specific requirements related to documentation or treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications and adverse reactions." "Treatment and therapy request will be coordinated with the provider for new orders and renewals."	01970		

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01970	Continued From page 84 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	02040		

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02040	Continued From page 85 Findings include: On June 27, 2023, at approximately 3:15 p.m., records were provided for review. Records were reviewed by survey staff on June 27, 2023, between 3:15 p.m. and 4:15 p.m. Record review of the available documentation indicated that the licensee had included a hazard and vulnerability ssessment tool that identified natural, technological, and human hazards. An assessment of the physical environment that identified safety risks or hazards on and around the property had not been completed. On June 27, 2023, at approximately 4:30 p.m., maintenance (M)-F verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(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
02110	Continued From page 86 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to four of four residents (R2, R3, R4, R5) and the legal and designated representatives at the time of move in. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02110		

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02110	Continued From page 87 The findings include: The licensee failed to provide residents and their legal and designated representatives policies that addressed: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and drills only; -transportation coordination and assistance to and from outside medication appointments; and -safekeeping of resident's possessions. R2 R2 began receiving services under the assisted living with dementia care licensure on September 25, 2020. R2's record lacked evidence the above noted dementia care policies had been provided to R2	02110		

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	32647	A. BUILDING: _____ B. WING _____	06/30/2023

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02110	Continued From page 88 or R2's representative. R3 R3 began receiving services under the assisted living with dementia care licensure on October 19, 2022. R3's record lacked evidence the above noted dementia care policies had been provided to R3 or R3's representative. R4 R4 began receiving services under the assisted living with dementia care licensure on June 13, 2022. R4's record lacked evidence the above noted dementia care policies had been provided to R4 or R4's representative. R5 R5 began receiving services under the assisted living with dementia care licensure on August 1, 2021. R5's record lacked evidence the above noted dementia care policies had been provided to R5 or R5's representative. On June 28, 2023, at 1:08 p.m. registered nurse (RN)-B stated there was no evidence in the resident record the dementia care policies had been provided. The licensee's Admission Process for New Clients policy, undated, identified "Information to Share with Client Prior to the Initiation of Services. Prior to the initiation of any home care service, the RN ensures that the following information is given to the client and/or the client's	02110		

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02110	Continued From page 89 representative in writing, that it is explained to the client and/or the client's representative, and that the client and/or the client's representative acknowledges, in writing, receipt of the information: a. Home Care Bill of Rights. b. Dementia Disclosure. Areas of required training include: · An explanation of Alzheimer's disease and related disorders; · Assistance with activities of daily living · Problem-solving with challenging behaviors; and Communication Our Home Care agency shall provide (upon request) to consumers in written or in electronic form a description of the training, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subsection 2, clause (4). " The policy failed to identify the following required policies for Assisted Living with Dementia Care facilities would be provided to the resident or responsible party on admission: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications;	02110		

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02110	Continued From page 90 -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and drills only; -transportation coordination and assistance to and from outside medication appointments; and -safekeeping of resident's possessions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based	02170		

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02170	Continued From page 91 on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan with required content based on the evaluation, for one of two residents (R2) who received services under an assisted living with dementia care license. 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 was admitted on September 25, 2020, with a	02170		

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02170	Continued From page 92 diagnosis including dementia, kidney disease and major depressive disorder. R2's service plan dated September 22, 2022, indicated resident receives assistance with medication management, bathing, dressing, toileting, and transfers. R2's 90-day assessment dated March 13, 2023, indicated R2 was now on hospice and needed assistance with transfers and ambulation. R2's record lacked evidence the resident had been evaluated for current activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - physical abilities and limitations; - adaptations necessary for the resident to participate On June 29, 2023, at 9:40 a.m. Life Enrichment director (LED)-O stated R2's record failed to show a current activity plan. LED-O stated the last time an activity plan was completed was at admission in 2020. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	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	02310		

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02310	Continued From page 93 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R2, R3) with siderails. This resulted in an immediate correction order on June 28, 2023, at approximately 8:50 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: Upon entrance, registered nurse (RN)-B provided the current resident roster, which indicated 13 residents utilized siderails, including R2 and R3. R2 On June 27, 2023, at 9:15 a.m. the surveyor observed three unlicensed personnel (ULP) assisting with getting resident up for the day. R2 was lying in a hospital bed with bilateral half siderails at the head of the bed in the up position. R2 began receiving services from the licensee on September 5, 2020, with a diagnosis of dementia. R2's service plan dated August 11, 2022, included	02310		

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02310	Continued From page 94 medication management and assistance with activities of daily living (ADLs) Additionally, the service plan indicated side rails were used as an assistive device. R2's record included an undated, Risks of Siderail Use form signed by the nurse and a designated representative, and a "Bedrail Safety Checklist" (used as the side rail assessment) dated June 27, 2023. R2's record lacked evidence a siderail assessment was completed prior to the start of the survey. R3 On June 27, 2023, at 11:00 a.m. the surveyor observed R3's apartment contained a hospital bed with bilateral half siderails at the head of the bed in the up position. R3 began receiving services from the license on October 19, 2023, with a diagnosis of unspecified dementia and atrial fibrillation (abnormal heart rhythm). R3's service plan dated January 4, 2023, indicated R3 received medication management and assistance with ADLs. The service plan lacked evidence an assistive device was being used. R3's record lacked evidence a siderail assessment was completed prior to the start of the survey, or evidence of reviewing the risks and benefits of side rail use with the resident and/or the the resident representative. On June 27, 2023, at 2:15 p.m. RN-B stated they were not sure if siderail assessments were	02310		

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02310	Continued From page 95 completed, so staff were instructed to complete the Bed Rail Safety Checklist for all residents utilizing siderails. On June 28, 2023, at 8:50 a.m. licensed assisted living director (LALD)-A provided four side rail assessments that had been completed prior to survey entrance and further stated that was all they could find. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Physical Devices and Bedrails Policy revised March 15, 2023, indicated devices will be assessed prior to use and at minimum quarterly for appropriate dimensions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *06/30/23*
Time: 07:35:09
Report: 1038231503

Food and Beverage Establishment Inspection Report

Location:
The Homestead At Rochester
5530 Ballington Road Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0038243
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075352000
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Three Compartment SInk
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Cheese Slices
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: Cucumber Slices
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: Tomatos
Violation Issued: No

Type: Full
Date: *06/30/23*
Time: 07:35:09
Report: 1038231503
The Homestead At Rochester

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Freezer
Temperature: -10 Degrees Fahrenheit - Location: Pork Tenderloin
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: French Fries
Violation Issued: No

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

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

darci.baumann-fern@curahospitality.com

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 1038231503 of 06/30/23.

Certified Food Protection Manager Beau Bergmann

Certification Number: FM111428 Expires: 05/11/25

Signed: _____
Beau Bergmann
Manager

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us