DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 25, 2023

Licensee
Nagel Assisted Living
232 Elm Street South
Waconia, MN 55387

RE: Project Number(s) SL31214015

Dear Licensee:

On September 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 651-431-5000 Fax: 651-281-9796

PMB

Electronically Delivered

July 25, 2023

Licensee
Nagel Assisted Living
232 Elm Street South
Waconia, MN 55387

RE: Project Number(s) SL31214015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
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 $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter

as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	31214	A. BUILDING: ________ B. WING ________	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31214015 On June 20, 2023, through June 23, 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 48 active residents; all receiving services under the Assisted Living with Dementia Care license. 2310: An immediate correction order was issued on June 22, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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

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0 250	Continued From page 2 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 show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on June 20, 2023, at 10:40 a.m., licensed assisted living	0 250		

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0 250	Continued From page 3 director/registered nurse (LALD/RN)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, 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 use information provided in this application, which	0 250		

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0 250	Continued From page 4	0 250		

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.

- I have examined this application and all

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0 250	Continued From page 5	0 250		

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)-M on May 18, 2021.

The licensee had an assisted living with dementia care 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:

- requirements in section 626.557, reporting of maltreatment of vulnerable adults;
- conducting and handling background studies on employees;
- implementation of the assisted living bill of rights;
- orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;
- 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, managed, and communicated to staff and other

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0 250	Continued From page 6 health care providers as appropriate; - infection control practices; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued: 0510, 0620, 0640, 0650, 1290, 1370, 1470, 1620, 1750, 1770, 1880, 1890, 1950, 2140, 2310, 2350, 2410, and 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 7 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 13, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current	0 510		

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0 510	Continued From page 8	0 510		

recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors.

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

The findings include:

On June 21, 2023, between 7:15 a.m. and 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to five different residents. ULP-C did not perform hand hygiene before, after, or in between any medication administration.

On June 21, 2023, at 8:35 a.m., the surveyor observed ULP-C administer oral medications, check blood glucose reading, and administer insulin to R2. ULP-C wore gloves to check R2's blood glucose but did not perform hand hygiene before or after donning and doffing gloves, and did not perform hand hygiene either before or after medication administration.

On June 21, 2023, at 10:30 a.m., ULP-C stated she was trained and should have washed or sanitized her hands between each medication pass, and before and after using gloves. ULP-C further stated she knew she was supposed to perform hand hygiene but felt rushed and forgot.

On June 21, 2023, at 10:30 a.m., licensed assisted living director/registered nurse

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0 510	Continued From page 9	0 510		

(LALD/RN)-A stated staff should wash their hands between each medication pass, and that is what they were trained to do.

The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal.

The licensee's Hand Washing policy dated August 1, 2021, indicated 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; and
- after touching garbage.

Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations.
When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after

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0 510	Continued From page 10 removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for suspected maltreatment and complete a thorough investigation for two of two residents (R9, R10) who had an altercation with each other. 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:	0 620		

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0 620		0 620		

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R9
The licensee failed to immediately report the March 19, 2023, physical altercation between R9 and R10 to MAARC.

R9's diagnoses included Huntington's disease (a disease that causes progressive breakdown of nerve cells in the brain that impacts a person's functional abilities) and schizophrenia.

R9's Vulnerability, Safety, and Risk assessment dated March 28, 2023, indicated the resident was at risk for physical abuse from others.

R9's Resident Incident Report dated March 19, 2023, indicated that R9 had been hit in the mouth three times by R10 and was bleeding from the mouth.

R9's Progress Notes dated March 19, 2023, indicated R9 had accidentally rolled over R10's feet with his wheelchair and R10 punched R9 in the mouth three times which caused R9 to bleed out of his mouth. R9 was able to rinse the blood out of his mouth and there was no apparent injury. R9's father was called and visited with R9 and decided not to have R9 evaluated.

R10
The licensee failed to immediately report the March 19, 2023, physical altercation between R9 and R10 to MAARC.

R10's diagnoses included degeneration of nervous system due to alcohol, major depressive disorder, heart failure, essential hypertension, and alcohol dependence.

R10's Vulnerability, Safety, and Risk assessment dated June 2, 2021, indicated R10 has had

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0 620	Continued From page 12 several altercations over the last month involving other residents that included punching and hitting with objects. Crisis team has been involved and stated it is behavioral not mental heath related. Nurse Practitioner (NP) updated and ordered lab work. R10's Resident Incident Report dated March 19, 2023, indicated unlicensed staff observed R10 hitting another resident three in the face three times on camera. R10's Progress Notes dated March 19, 2023, at 6:51 p.m., indicated R10 allegedly hit another resident in the mouth three times for accidentally running over his foot with a wheelchair. R10 did not offer an explanation or answer any questions. He denied any injuries on himself. Family and case worker notified. R9 and R10's record both lacked evidence of this incident being reported to MAARC within 24 hours of the incident occurring. On June 21, 2023, at 10:15 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the facility did not file a MAARC report on this incident, and she was unaware this incident would need to be filed. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated if the Assisted Living Director or Clinical Nurse Supervisor confirm the suspicion of maltreatment, they will contact the MAARC. Such report must be made no later than 24 hours after the maltreatment was suspected. No further information was provided.	0 620		

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0 620	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 48 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 640		

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0 640	Continued From page 14 The findings include: On June 20, 2023, at 11:30 a.m., the surveyor completed the tour of the facility with housing director (HD)-K. The surveyor did not observe the 911 emergency number posted in common areas or near phones provided by the assisted living facility. On June 21, 2023, at 10:15 a.m., the licensed assisted living director/registered nurse (LALD/RN)-A stated she was unaware that a 911 sign needed to be posted at telephones provided by the facility. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated the facility will support protection and safety through access to the states systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: -Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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registration, or certification if licensure, registration, or certification is required by this chapter or rules;
(2) records of orientation, required annual training and infection control training, and competency evaluations;
(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;
(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;
(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and
(6) documentation of the background study as required under section 144.057.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-D and ULP-G).

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:

ULP-D

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ULP-D was hired on December 21, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021.

On June 21, 2023, from 7:00 a.m. to 9:00 a.m., the surveyor observed ULP-D administer medication to six residents.

ULP-D employee record lacked the following required content:
- competency evaluations to include the following:
  - setting up medications for an unplanned time away from home;
  - medication administration on all route procedures; and
  - administering treatments as ordered.
- record of annual training;
- record of 30-day supervision; and
- documentation of annual performance reviews that identify areas of improvement needed and training needs.

On June 22, 2023, at 3:22 p.m., ULP-D stated they were trained, and competency tested; however, ULP-D was unable to state what training they received due to the time that had passed. In addition, ULP-D stated they were trained, and competency tested for medication and treatments by a licensed practical nurse (LPN). The surveyor inquired if they received annual training with the required content. ULP-D stated they received annual training; however, they were not able to verify the topics provided by the licensee.

ULP-G
ULP-G was hired on September 24, 2020, under the licensee's former comprehensive license and

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started providing assisted living services August 1, 2021.

On June 23, 2023, at approximately 11:15 a.m., the surveyor observed ULP-G provide dressing, toileting, and transfer assistance to R17.

ULP-G's employee record lacked the following required content:
- records of 30-day supervision;
- competency evaluations which include the following:
  - setting up medications for an unplanned time away from home;
  - medication administration on all route procedures;
  -administering treatments as ordered;
  - appropriate and safe techniques in personal hygiene and grooming;
  - standby assistance techniques;
  - reading and recording temperature pulse and respirations of the resident;
  - safe transfer techniques and ambulation; and
  - range of motion and positioning.
- training which include the following:
  - documentation requirement for all services provided;
  - reports of changes in the resident condition to the supervisor;
  - appropriate and safe techniques in personal hygiene and grooming;
  - standby assistance techniques;
  - medication exercise and treatment reminders;
  - understanding appropriate boundaries between staff and resident and the resident's family;
  - procedures to utilize handling various emergency situations;

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- commonly used health technology equipment and assistive devices;
- observation, 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 appropriate personnel;
- recognizing physical, emotional, cognitive, and developmental needs of the resident;
- reading and recording temperature;
- safe transfer techniques and ambulation;
- range of motioning and positioning; and
- administering medications or treatments as required.
- records of annual training;
- current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and
- documentation of annual performance reviews that identify areas of improvement needed and training needs.

On June 23, 2023, at 8:46 a.m., ULP-G stated they completed a check off list of the training content listed above prior to working independently on the floor. In addition, ULP-G stated they completed the competencies listed above by a nurse; however, they were unable to state the title of the nurse who completed the competency evaluations. The surveyor inquired if they completed annual training. ULP-G stated they completed training online and in person yearly; however, they were unable to verify if all required topics occurred due to length of time that passed.

On June 22, 2023, at 2:16 p.m., the surveyor inquired if the licensee had completed annual training in the year 2022 with all employees.

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Licensed assisted living director/registered nurse (LALD/RN)-A stated, "We do, as I explained. I don't know where the papers are. I can not locate."

On June 22, 2023, at 4:03 p.m., LALD/RN-A stated they completed annual reviews; however, they would need to locate the annual reviews for the year of 2022 for ULP-D and ULP-G. The surveyor did not receive the performance reviews before the survey was completed.

On June 23, 2023, at 8:22 a.m., housing director (HD)-K stated what they provided the surveyor was the entire employee records for ULP-D and ULP-G.

On June 23, 2023, at approximately 8:30 a.m. LALD/RN-A stated all ULP received the same initial training regardless if they were a certified nursing assistant (CNA). LALD/RN-A stated they trained, and competency evaluated all ULP in the 22 required areas under 144G.61, subd. 2; however, they were located in a box that they were unable to locate. The surveyor inquired if the licensee completed 30-day supervisions on the delegated tasks. LALD/RN-A stated they completed 30-day supervisions on ULP; however, the supervisions were located in a box that they were unable to locate.

On June 23, 2023, at 8:38 a.m., LALD/RN-A stated some trainings that were not completed online would be completed in the paper format and competency evaluations would be completed in a paper format. In addition, LALD/RN-A stated the papers would cover all the requirements for 144.G; however, they were located in a box that they were unable to locate. The surveyor inquired how many trainings and competencies were

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located in the box. LALD/RN-A stated all employee trainings and competency evaluations since 2020 that were not online based.

The licensee's Employee Records dated August 1, 2021, indicated the licensee would keep an employee record for all paid employees. In addition, the employee records for each person would include the following:
-evidence of current professional licensure, registration or certificate if required;
-records of all training and inservice education required and or provided including record of competency testing as required;
-documentation of annual performance reviews that identify areas of improvement needed and training needs; and
-verification of completed orientation and annual training and competency testing as required.

The licensee's Volunteer and Contractor Records dated August 1, 2021, indicated the licensee would maintain a record for each individual contractor providing assisted living services. In addition, the contractor records for each person would include documentation of annual performance reviews that identify areas of improvement needed and training needs.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

0 680 SS=F | 0 680

144G.42 Subd. 10 Disaster planning and emergency preparedness

(a) The facility must meet the following requirements:

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(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;
(2) post an emergency disaster plan prominently;
(3) provide building emergency exit diagrams to all residents;
(4) post emergency exit diagrams on each floor; and
(5) have a written policy and procedure regarding missing residents.
(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to have a written emergency disaster preparedness plan with all required content. 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

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0 680	Continued From page 22 a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Develop and Maintain the EP; - Maintain and Annual EP Updates; Last revised July 28, 2021. - Emergency Prep Testing Requirements. Last updated August 8, 2021. On June 23, 2023, at 10:48 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated knowing Appendix Z was not updated annually. The licensee's Emergency Preparedness - Appendix Z Compliance policy dated August 1, 2021, indicated the plan will be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790		

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fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to comply with the provisions of the Minnesota State Fire Code and failed to provide smoke alarms in the resident sleeping rooms. This deficient condition had the ability to affect all staff and 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, 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).

Findings include:

On a facility tour on June 21, 2023, at approximately 1:50 p.m. with Maintenance (M)-E, it was observed that east side rooms #100,#101,#102,#103,#104,#105,#106,#107,#108,#109,#110,#111 and #112, lower east rooms #200, #201,#202, #203,#204,#205 and #206, and lower center rooms #208, #209, #210 and #211, did not have smoke alarms installed in the resident sleeping rooms.

M-E verbally confirmed survey staff observations during the facility tour.

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0 790	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This deficient condition had the ability to affect a limited number of residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 21, 2023, from approximately 1:35 p.m. to 2:45 p.m., survey staff toured the facility with Maintenance (M)-E. During the facility tour,	0 800		

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0 800	Continued From page 25 survey staff observed the following maintenance issues: There were Carpet stains in resident rooms #114,#117, #119 and #124 and memory care medication room. The carpet in resident rooms #114 and #124 smelled like urine. There were stained ceiling tiles, sprinkler head and vent full of lint in resident room #118. Dining room fire doors in memory care were propped open with a chair and humidifier. M-E verbally confirmed all survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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	0 810		

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0 810	Continued From page 26 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 810		

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0 810		0 810		

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a large portion or all of the residents).

Findings include:

A record review and interview were conducted on June 21, 2023, at approximately 3:15 p.m. with Maintenance (M)-E, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.

Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency.

Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.

Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents.

Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire.

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0 810	Continued From page 28	0 810		

Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute.

During interview, M-E, verified that the fire safety and evacuation plan for the facility lacked these provisions.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

0 950 SS=C — 144G.50 Subd. 3 Designation of representative — 0 950

(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

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0 950	Continued From page 29	0 950		

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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.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to include verbatim language giving residents the right to identify a designated representative for four of four residents (R2, R3, R4, R5).

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 the potential to affect a large portion or all the residents).

The findings include:

On June 20, 2023, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A provided a blank copy of their Resident Agreement and stated it was the Resident Agreement currently in use with their residents. The blank Resident Agreement included space for a resident to select a designated representative on page 23, but lacked the required verbatim language on its own page separate from the contract.

R2, R3, R4 and R5's signed Resident

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0 950	Continued From page 30 Agreements were reviewed and lacked the required verbatim language giving the right to identify a designated representative. On June 22, 2023, at 10:35 a.m., LALD/RN-A stated they were unaware of the required verbatim language requirement for a designated representative, and it would not be in any of the current resident contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01290 SS=C	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 submitted and a clearance	01290		

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01290	Continued From page 31 received in affiliation with the assisted living with dementia care licensee's current health facility identification (HFID) for two of three employees (unlicensed personnel (ULP)-D, ULP-G). 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: ULP-D ULP-D was hired on December 21, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021. On June 21, 2023, from 7:00 a.m. to 9:00 a.m., the surveyor observed ULP-D administer medication to six residents. ULP-D's employee record included a background study clearance dated November 20, 2020, affiliated with the licensee's former comprehensive HFID license #32085. Although the licensee converted from comprehensive license to assisted living licensee on August 1, 2021, the licensee continued to submit background checks under the comprehensive license. ULP-G ULP-G was hired on September 24, 2020, under the licensee's former comprehensive license and started providing assisted living services August	01290		

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01290	Continued From page 32 1, 2021. On June 23, 2023, at approximately 11:15 a.m., the surveyor observed ULP-G provide dressing, toileting, and transfer assistance to R17. ULP-G's employee record included a background study clearance dated September 11, 2020, affiliated with the licensee's former comprehensive HFID license #32085. Although the licensee converted from comprehensive license to assisted living licensee on August 1, 2021, the licensee continued to submit background checks under the comprehensive license. ULP-D and ULP-G's employee records lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care HFID license #31214, effective August 1, 2021. On June 22, 2023, at 4:20 p.m., the surveyor observed Minnesota (MN) Department of Human Services (DHS) NETStudy2.0 (web-based system used to submit background study request) which indicated ULP-D and ULP-G lacked a background study affiliated with the licensee's current HFID #31214. In addition, the roster indicated 24 employees were affiliated with current HFID number and current employee roster contained 50 employees. On June 22, 2023, at 4:03 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee ran background studies on all employees. The surveyor inquired if the licensee completed new background studies when the licensee converted from a comprehensive license to an assisted living with dementia care license.	01290		

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LALD/RN-A stated, "I honestly don't know. I would have to check with HR [human resources]."

The licensee's Background Studies policy dated August 1, 2021, indicated using the MN DHS NETStudy online program the licensee would initiate a background study on all employees being considered for hire. In addition, no employee may provide direct services and have independent direct contact with any resident until acceptable result of the background study had been received.

No further information was provided.

TIME PERIOD FOR CORRECTION: Two (2) days

01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn | 01370

(a) Training and competency evaluations for all unlicensed personnel must include the following:
(1) documentation requirements for all services provided;
(2) reports of changes in the resident's condition to the supervisor designated by the facility;
(3) basic infection control, including blood-borne pathogens;
(4) maintenance of a clean and safe environment;
(5) appropriate and safe techniques in personal hygiene and grooming, including:
(i) hair care and bathing;
(ii) care of teeth, gums, and oral prosthetic devices;
(iii) care and use of hearing aids; and
(iv) dressing and assisting with toileting;
(6) training on the prevention of falls;

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(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 training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (ULP-F).

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:

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ULP-F began working for the licensee July 2022, through a staffing agency to provide direct care services to residents.

On June 21, 2023, at 7:20 a.m., the surveyor observed ULP-F provide cares to one unidentified resident.

ULP-F's record lacked the following training and competency evaluations:
-care and use of hearing aids; and
-training on the prevention of falls

On June 23, 2023, at 9:18 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the staffing company they contracted ULP-F from should have trained and completed competency evaluations for ULP-F. The surveyor requested the information specifically listed above. The surveyor did not receive further training or competency evaluations for ULP-F prior to survey completion.

The licensee's Competency Training Evaluations dated August 1, 2021, indicated the licensee must make certain the unlicensed personnel are trained in the proper methods to perform the task or procedures for each client [resident] and are able to demonstrate the ability to competently follow the procedure and perform the task. In addition, training and competency evaluations for all ULP would include care and use of hearing aids and training on the prevention of falls.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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01470	Continued From page 36	01470		
01470 SS=F	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	01470		

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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;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-D, ULP-F, ULP-G).

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

The findings include:

ULP-D

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ULP-D was hired on December 21, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021.

On June 21, 2023, from 7:00 a.m. to 9:00 a.m.., the surveyor observed ULP-D administer medication to six residents.

ULP-D's record included MN Guide to Home Care Services dated December 21, 2020, and Home Care Bill of Rights dated April 12, 2021; however, it lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:
- an overview of this assisted living statutes; and
- the assisted living bill of rights (BOR).

ULP-F
ULP-F began working for the licensee July 2022, through a staffing agency to provide direct care services to residents.

ULP-F's record included Regulation of Home Care Services dated January 10, 2023; however, it lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:
- an overview of this assisted living statutes.

ULP-G
ULP-G was hired on September 24, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021.

On June 23, 2023, at approximately 11:15 a.m., the surveyor observed ULP-G provide dressing, toileting, and transfer assistance to R17.

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01470	Continued From page 39 ULP-G's record included an undated Orientation to MN Home Care Services Education Quiz and Home Care Bill of Right dated March 31, 2021; however, it lacked documented evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of this assisted living statutes; and - the assisted living BOR. On June 22, 2023, at 2:19 p.m., licensed assisted living director/registered nurse (LALD/RN)-A verified ULP-D, ULP-G records lacked an overview of assisted living statues and the assisted living BOR. LALD/RN-A stated they believed employees received training to the assisted living BOR upon hire and yearly. The surveyor inquired if employees received training on the assisted living statues when the licensure changed. LALD/RN-A stated they were unsure, but believed they may have. On June 23, 2023, at 8:21 a.m., housing director (HD)-K they believed the employees received the assisted living BOR not the home care bill of rights; however, the licensee forgot to change the documentation of education provided. The licensee's Employee General Orientation dated August 1, 2021, indicated each new employee and volunteer would be oriented in accordance with state and federal regulations as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01620	Continued From page 40	01620		
01620 SS=E	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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment within the required 90-day timeframe for three of four residents (R2, R4, R5). In addition, the licensee failed to ensure the RN completed an assessment not to exceed 14 days of start of services for three of four residents (R3, R4, R5).	01620		

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01620	Continued From page 41	01620		

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

The findings include:

R2
R2 was admitted to the licensee on December 3, 2019.

R2's record indicated 90-day comprehensive nursing assessments were completed on June 24, 2022, and October 7, 2022, 105 days apart and a change in condition nursing assessment was completed November 28, 2022. No further nursing assessments had been completed.

R3
R3 was admitted to the licensee on December 13, 2022.

R3's record indicated a 14-day comprehensive nursing assessment was completed on January 6, 2023, 24 days after services began.

R4
R4 was admitted to the licensee on August 10, 2022, for assisted living services.

R4's record included the following assessments: an initial Comprehensive Assessment dated August 11, 2022, a Comprehensive Assessment dated December 7, 2022 (108 days from the

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01620	Continued From page 42	01620		

previous assessment), and a Comprehensive Assessment dated April 27, 2023 (141 days from the previous assessment).

R5
R5 started services on February 6, 2023, for assisted living services..

R5's record included an initial assessment completed on February 6, 2023, and a change in condition assessment dated April 2, 2023 (55 days from the first survey). R5's record lacked an assessment to be completed within 14 days after the initiation of services, and an assessment not to exceed 90 days after the previous assessment.

On June 20, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated nursing assessments are completed upon admission, 14 days, 90 days, and with a change in condition.

On June 21, 2023, at 10:30 a.m., LALD/RN-A stated she was aware nursing assessments were late and further stated "I have no excuse, it's hard to keep up with everything."

The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 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.

No further information was provided.

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01620	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for one of four residents (R2).	01640		

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01640	Continued From page 44	01640		

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

The findings include:

R2's signed Service Plan dated May 4, 2022, included services of bathing, behavior monitoring, meals, dressing, grooming, pain management, laundry, housekeeping, medication administration, smoking assistance, toileting, continence assistance, and blood glucose monitoring. The total monthly payer cost was $4796.34.

R2's unsigned Service Plan with print date of June 20, 2023, included services of bathing, behavior monitoring, meals, dressing, grooming, pain management, laundry, housekeeping, medication administration, smoking assistance, continence assistance, toileting, blood glucose monitoring, and oxygen assistance and management. The total monthly payer cost was $5063.28.

R2's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provided by licensee after addition of services on or after May 4, 2022.

On June 23, 2023, at 9:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the service plan should be signed

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whenever there is a change. LALD/RN-A stated some have gotten missed.

The licensee's Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by [facility] and by the resident, or resident's representative, documenting agreement on the services to be provided.

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750		

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 prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to

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01750	Continued From page 46	01750		

perform the task or procedure for each resident and verified one of two ULP (ULP-D) was able to demonstrate the ability to competently follow the procedure.

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:

ULP-D was hired on December 21, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021.

On June 21, 2023, from 7:00 a.m. to 9:00 a.m., the surveyor observed ULP-D administer medication to six residents.

ULP-D's employee record lacked a competency evaluation completed by a RN for medication administration.

On June 22, 2023, at 2:18 p.m., the surveyor inquired if the licensee had medication competency evaluations. Licensed assisted living director/registered nurse (LALD/RN)-A stated, "I know they were all done, but I am unable to locate them."

On June 22, 2023, at 3:24 p.m., ULP-D stated the licensee trained them on medication administration by shadowing a ULP for two weeks

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01750	Continued From page 47	01750		

then shadowing a licensed practical nurse (LPN) for period of time. The surveyor inquired if ULP-D received a competency evaluation on medication administration. ULP-D stated they completed the medication competency with a LPN.

On June 22, 2023, at 3:54 p.m., LALD/RN-A stated ULP were trained on medication administration in a one-to-one setting or a one-to-two setting with verbal communication, and visually showing the ULP the process. In addition, LALD/RN-A stated this occurred upon hire and annually. The surveyor inquired if an ULP received a competency evaluation on all medication administration performed at the facility. LALD/RN-A stated, "yes with one of the nurses." The surveyor inquired if it was a RN or a LPN who completed the competency evaluations. LALD/RN-A stated the LPNs completed the competency evaluations and then would provide the RN the competency evaluation to cosign. The surveyor inquired how many competency evaluations were completed by LPNs. LALD/RN-A stated they were not aware of how many medication administration competency evaluations were completed by a LPN; however, they believed it was over five ULP.

The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated a RN or a LPN when appropriate, will determine what nursing services may be delegated to properly trained and competency tested ULP. In addition, training and competency evaluations of ULP would be conducted by a RN or another instructor may provide the training in conjunction with a RN.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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01750	Continued From page 48 days	01750		
01770 SS=F	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 included all the required content for one of one resident (R14). 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 the residents). The findings include: R14's record lacked medication set-up documentation to include quantity of doses, times to be administered, and routes of administration. On June 23, 2023, at 9:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the nurses completed medication set-ups for some of the residents such as the veterans	01770		

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who get their medications in bottles and for new residents who bring in bottles of medication to be used before ordering punch packs from the pharmacy. The nurse then wrote progress notes which included the date of the medication set-up, the name of the medication, the dose of the medication, and the name of the person completing the medication set-up. LALD/RN-A stated she was not aware of all the requirements for documentation of medication set-ups.

The licensee's Medication Management-Dosage Box Setup policy dated August 1, 2021, indicated a licensed nurse will assure the medication orders are transcribed onto the Medication Administration Record (MAR). This profile includes: a. dates of medication setup, b. Medication name, c. Quantity of dose, d. Times to be administered, e. Route of administration, f. Name of the person completing the medication set up, g. Visual description of medication, and h. Drug classification and special precautions.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01880 SS=F | 144G.71 Subd. 19 Storage of medications | 01880

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

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review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for both medication refrigerators currently in use.

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 the residents).

The findings include:

On June 21, 2023, at 7:30 a.m. the surveyor observed the medication refrigerator in the secured unit with unlicensed staff (ULP)-D. ULP-D stated she was not aware of a temperature log and would need to ask the nurse.

During the above observation, ULP-D verified the following resident medications were being stored:
-one unopened Lantus 100 units/ml insulin pen (long acting insulin used to reduce blood sugars).

On June 21, 2023, at 7:30 a.m. the surveyor observed the medication refrigerator in the unsecured unit with ULP-D. ULP-D stated the temperature log located on top of the refrigerator must be the only log and would need to ask the nurse. On top of the refrigerator were temperature logs dated May 2023 to June 2023. The temperature log dated May 2023, only contained five of the 31 readings and two of the readings indicated it was below the

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recommended temperature range of 36-46 degrees Fahrenheit. The temperature log dated June 2023, only contained 12 of the 21 readings.

During the above observation, ULP-D verified the following resident medications were being stored:
-one unopened Novolog Flex 100 u/ml insulin pen (short acting insulin)
-one unopened Lantus 100 units/ml insulin pen
-one unopened Humalog 100 units/ml insulin pen (short acting insulin)
-one unopened bottle of latanoprost ophthalmic solution (a glaucoma eye drop solution)

The manufacturer's instructions for Lantus insulin pens dated 2022, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze.

The manufacturer's instructions for Novolog insulin pen dated 2023, indicated to store unopened Novolog in the refrigerator at 36-46 degrees F and do not freeze.

The manufacturer's instructions for Humalog insulin pen dated April 2020, indicated to store unopened Humalog in the refrigerator at 36-46 degrees F and do not freeze.

The manufacturer's instructions for latanoprost eye drops dated, December 2022, indicated the unopened bottles should be stored in the refrigerator between 36 to 46 degrees F.

On June 21, 2023, at 9:00 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the secured unit medication refrigerator does not have a temperature log and the log for the unsecured unit is the only log they have. LALD/RN-A stated the staff should be recording

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the temperature once a day.

The licensee's Medication Storage policy dated August 1, 2021, indicated medications are managed and stored by the licensee medications will be kept securely locked and stored per manufacturer's directions.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01890 SS=E — 144G.71 Subd. 20 Prescription drugs — 01890

A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to monitor for expired medications for five of fifteen residents (R5, R9, R17, R18, and R19).

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

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01890		01890		

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found to be pervasive).

The findings include:

On June 20, 2023, at 10:40 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A indicated the licensee provided medication administration to all residents.

On June 21, 2023, at 7:45 a.m., the surveyor observed the medication cart in the secured unit with unlicensed personnel (ULP)-D. The surveyor noted expired medications for R5, R9, R17, R18, and R19. ULP-D confirmed expired medications with the surveyor.

R5 had the following expired medications:
-Tylenol 500 mg (for pain), expired on May 4, 2023; and
-loperamide 2 mg (for loose stools), expired on February 22, 2023.

R9 had the following expired medications:
- Tylenol 650 mg (for pain), expired on March 18, 2023; and
- Banophen 25 mg (for allergies), expired on March 22, 2023.

R17 had the following expired medications:
-morphine 5 mg (for pain), expired February 2023.

R18 had the following expired medications:
-Tylenol 1000 mg (for pain), expired on December 30, 2022; and
-Seroquel 25 mg (antipsychotic), expired on April 26, 2023.

R19 had the following expired medications:

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01890	Continued From page 54 -loperamide 2 mg (for loose stools), expired on July 22, 2022. On June 21, 2023, at 10:15 a.m., LALD/RN-A stated the nurse should be checking the medication carts for expired medications once a week, and she was unaware there were expired medications in the medication cart. The licensee's 7.23 Medication Storage policy dated August 1, 2021, indicated the licensee would store medications consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	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	01950		

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01950	Continued From page 55	01950		

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 registered nurse (RN) failed to ensure prior to delegating nursing tasks of prescribed treatment administration, one of two unlicensed personnel (ULP-D) was trained in the proper methods to perform the task or procedure for each resident, and was able to demonstrate the ability to competently follow the procedure.

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:

ULP-D was hired on December 21, 2020, under the licensee's former comprehensive license and started providing assisted living services August 1, 2021.

On June 21, 2023, at 11:00 a.m., the surveyor observed ULP-D complete blood glucose monitoring to R4.

ULP-D's employee record lacked a competency evaluation for blood glucose monitoring.

On June 20, 2023, at 10:00 a.m., during entrance conference, registered nurse/licensed assisted

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living director (RN/LALD)-A stated the licensee provided oxygen therapy, compression stocking application and removal, blood glucose monitoring, and simple wound care.

On June 22, 2023, at 2:18 p.m., the surveyor inquired if the licensee had oxygen, blood glucose, ted stocking, and wound care competency evaluations for all ULP. LALD/ RN-A stated, "I know they were all done, but I am unable to locate them."

On June 22, 2023, at 3:24 p.m., ULP-D stated they were trained, and competency tested for treatments by a licensed practical nurse (LPN).

On June 22, 2023, at 3:54 p.m., LALD/RN-A stated ULP were trained on treatments in a one-to-one setting or a one-to-two setting with verbal communication, and visually showing the ULP the process. In addition, LALD/RN-A stated this occurred upon hire and annually. The surveyor inquired if a ULP received a competency evaluation on all treatments performed at the facility. LALD/RN-A stated, "yes, with one of the nurses." The surveyor inquired if it was a RN or a LPN who completed the competency evaluations. LALD/RN-A stated the LPNs completed the competency evaluations and then provided the RN the competency evaluation to cosign. The surveyor inquired how many competency evaluations were completed by LPNs. LALD/RN-A stated they were not aware of how many treatment competency evaluations were completed by LPN; however, they believed it was over five ULP.

The licensee's Staffing Requirement- Licensed Nurse and ULP policy dated August 1, 2021, indicated ULP performing therapy or treatment

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01950	Continued From page 57 tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks and any other training or competency requirement within the licensed health professional scope of practice relating to delegation or assignment of tasks to ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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 hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. 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	02040		

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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).

Findings include:

A record review and interview were conducted on June 21, 2023, between approximately 3:30 p.m. Maintenance (M)-E on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. During interview, M-E stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

02110 SS=C | 144G.82 Subd. 3 Policies | 02110

(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

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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 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 the assisted living facility with dementia care provided the required policies and procedures to resident's legal and designated representatives at time of move in for three of three residents (R2, R3, R4).

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

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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:

The facility currently held an Assisted Living with Dementia Care license.

R2 was admitted to licensee on December 3, 2019, and started receiving assisted living services August 1, 2021.

R3 was admitted to licensee on December 13, 2022.

R4 was admitted to licensee on August 3, 2022.

R2, R3, and R4's records lacked evidence the resident or residents' representative were provided the additional required policies and procedures for assisted living facilities with dementia care.

On June 23, 2023, at 10:35 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they were not aware the dementia policies were required to be given to the resident or their representative at time of move in, and they do not have evidence of any of the residents received the policies at time of move in.

The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2021, indicated the licensee must provide these policies and procedures to residents and the resident's legal and designated representatives at the time of

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02110	Continued From page 61 move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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 the residents). The findings include:	02140		

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On June 20, 2023, at 10:30 a.m. during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated dementia trainer (DT)-L is the person who does all the dementia training and was unsure if she had completed a competency or knowledge test related to dementia training.

On June 22, 2023, at approximately 3:00 p.m., the surveyor received a copy of an email stating "I'm not sure what certificate they are referring to. I can provide my resume and include the trainings on dementia I have completed, including Naomi Feil's validation therapy worker and group work as well as Teepa Snow's training. I have not completed any official Dementia Certificate program."

The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, indicated persons conducting such training will be qualified to train in the care of individuals with dementia. Qualification will include the following: a. two years work experience related to Alzheimer's disease or other dementias, or in other health care, gerontology, or another related field, and; b. has completed and passed training approved by MDH.

No further information was provided.

TIME PERIOD TO CORRECT: Twenty-one (21) days

02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In

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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 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 ensure an individualized activity plan contained all required content for one of one resident (R4).

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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:

R4 was admitted to the licensee on August 10, 2022, and resided in licensee's secured unit.

R4's diagnoses included but were not limited to diabetes-type II, alcohol dependence, and severe protein-calorie malnutrition.

R4's record lacked an evaluation for activities which included the following:
-past and current interests;
-current abilities and skills;
-emotional and social needs and patterns;
-physical abilities and limitations;
-adaptations necessary for the resident to participate;
-identification of activities for behavioral interventions; and
-a fully completed individual activity plan.

On June 23, 2023, at 9:45 a.m., activities director (AD)-H stated she had just recently started this position and none of the residents had a current activity evaluation completed. AD-H stated she has only completed five evaluations so far and started with the residents in the unsecured unit.

No further information provided.

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	TIME PERIOD FOR CORRECTION: Twenty-one (21) days			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		
	(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R6, R11) with an assistive device (consumer side rail and hospital side rail), which resulted in an immediate correction order. In addition, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R7) with oxygen.			
	This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).			
	The findings include:			

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BED RAILS
R6
On June 22, 2023, at 8:15 a.m., the surveyor observed R6's consumer side rail which was on the left side of the bed and was a black metal bar that was flush with the mattress and bent into an oval shape. The oval opening of the side rail was covered with a black cloth detachable organizer pouch. The metal bar attached to a wooden base that slips beneath the mattress and was secured to the bed frame with a safety strap.

R6's diagnoses included diabetes type II, hemiplegia, hemiparesis following cerebral infraction affecting the left non-dominant side (stroke causing left sided paralysis), and chronic obstructive pulmonary disease.

R6's Side Rail Use Assessment Form dated March 10, 2021, indicated R6 had poor bed mobility, difficulty with balance, poor trunk control, and medications which may require safety precautions. The assessment indicated R6 used the side rail for positioning or support and had expressed a desire to have side rails raised while in bed for safety and comfort. The assessment indicated the positive and negative aspects of side rail use had been discussed with the resident and the resident was aware of the risks involved with side rail use.

R6's Comprehensive Assessment dated April 12, 2023, indicated R6 needs reminders for transfers, but can stand independently. The assessment indicated that R6 needs verbal reminders for getting in and out of bed but can get up independently. The assessment indicated R6 used half bed rails for bed mobility and the rails were not used to restrict the R6's ability to get in or out of bed.

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NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

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R6's record lacked:
- Documentation of installation and use according to manufacturer's guidelines;
- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and
- Documentation the licensee reviewed the United States Consumer Product Safety Commission (CPSC) website for portable side rail recalls.

On June 22, 2023, R6 stated he did not use the bed rail to get in and out of bed and he only wanted it so he did not feel like he would roll out of bed.

On June 22, 2023, at 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she does not have the manufacturer's guidelines for the consumer bed rail and she has not checked the recall list every 90 days.

R11
On June 22, 2023, at 8:25 a.m., the surveyor observed a bilateral (two sides) side rails on R11's hospital bed. The bedrails were shaped rectangular and measured approximately 16 inches in width by eight inches in height, the mid-section had vertical bars spaced at approximately four inches apart. The bed rail was attached to the hospital bed in a vertical position rather than the side position, as it was intended to be used.

R11's diagnoses included cerebral palsy, schizoaffective disorder, anxiety, borderline personality disorder, and major depressive disorder.

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02310	Continued From page 68 R11's Side Rail Use Assessment Form dated October 7, 2020, indicated R11 is non-ambulatory, had a history of falls, had poor bed mobility, difficulty with balance, poor trunk control, and medications which may require safety precautions. The assessment indicated R11 used the side rail to serve to promote independence and assist with positioning. The assessment indicated the positive and negative aspects of side rail use had been discussed with the resident and the resident was aware of the risks involved with side rail use. R11's Comprehensive Assessment dated March 21, 2023, indicated R11 was independent with transfers. The assessment indicated that R11 needed physical assist of one person for getting in and out of bed. The assessment indicated R11 used half bed rails for bed mobility and the rails are not used to restrict the R11's ability to get in or out of bed. R11's record lacked: - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Measurements were completed and documented. On June 22, 2023, at 11:00 a.m., LALD/RN-A stated that she was not aware that any measurements were required for the hospital bed rails. On June 22, 2023, LALD/RN-A stated she thought Eldermark (computer charting system) had everything built in that was needed for the state requirements on bed rails.	02310		

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The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.

The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and

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Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4.
- Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth.
- Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches.
- Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches.
- Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle.

The licensee's 6.28 Side Rail policy effective/revised date of August 2022, indicated the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side

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rails, and verify that the side rail in use is of safe design and utilized consistent with the manufacturer's directions.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 21, 2023, indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices and documentation about a resident's bed rails includes, but is not limited to:
- Purpose and intention of the bed rail;
- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;
- The resident's bed rail use/need assessment;
- Risk vs. benefits discussion (individualized to each resident's risks);
- The resident's preferences;
- Installation and use according to manufacturer's guidelines;
- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and
- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."

No further information was provided.

TIME PERIOD FOR CORRECTION: Immediate

On June 23, 2023, the immediacy of correction order 2310 was removed, however the scope and level remain unchanged.

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OXYGEN
R7's Service Plan Agreement dated May 4, 2022, indicated R7 received the following services: medication administration to include oxygen administration as needed.

On June 21, 2023, at 2:18 p.m., the surveyor observed R7's six portable oxygen tanks standing beside her wall and were not secured in a rack.

On June 21, 2023, at 10:15 a.m., LALD/RN-A stated all oxygen tanks were stored in the resident's room and if the supplier brings a holder we will store the oxygen tanks in the holder. LALD/RN-A stated she was not aware that oxygen tanks must be stored in a holder.

The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over.

The licensee's oxygen policy dated August 1, 202, indicated oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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02350	Continued From page 73	02350		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to treat a resident with courtesy and respect when personal property was withheld to gain resident compliance. 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 began receiving services on December 3, 2019. R2's signed service plan dated May 4, 2022, indicated R2 received services to include bathing, behavior management, dressing, grooming, medication administration, toileting, and smoking assistance. The service type: toileting included a note indicating *ensure resident is toileting during the day before she gets a cigarette every 2 hours. R2's MAR (medication administration record) for June 2023, included change briefs- get resident up to toilet and change brief; bribe with cigarette, if she refuses let her know 1) she will not receive	02350		

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her cigarette and 2) she risks going to hospital due to skin break down, change briefs, effective September 16, 2020.

On June 23, 2023, at 10:40 a.m., R2 stated it was unfair that she needs to change her brief before she can get a cigarette. "I know when to change my brief, I know if it's dirty or not."

On June 23, 2023, at 10:15 a.m., licensed assisted living director/registered nurse (LALD/RN)- A stated bribing the resident to change her brief for a cigarette stems from R2's sister who provided the cigarettes, but was not a guardian or power of attorney for R2. LALD/RN-A stated she did not agree with this practice and deleted it from R2's cares.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

02410 SS=F | 144G.91 Subd. 13 Personal and treatment privacy | 02410

(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.
(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted

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in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.
(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure privacy in all double and triple occupancy rooms.

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 the residents).

The findings include:

On June 20, 2023, at 10:45 a.m., during a tour of the facility, the surveyor observed residents sharing rooms. None of the rooms observed had privacy curtains or other means to establish privacy in the shared space.

On June 22, 2023, at 8:40 a.m., R6 stated the lack of privacy did not bother him too much, and there had never been a curtain in his shared room for privacy.

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02410	Continued From page 76 On June 22, 2023, at 8:45 a.m., R12 stated there was not a privacy curtain in his room like in other places he has been and would like some privacy. R13 stated that he was human, so of course he would like some privacy. On June 23, 2023, at 10:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they cannot put up privacy curtains for fire safety due to where sprinklers and windows were in the room, and they cannot put anything on the floor like a partition because it will be a tripping hazard. LALD/RN-A further stated this would be true for all double and triple occupancy rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to	03000		

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

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to timely submit a report to the Minnesota Adult Abuse Reporting Center

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(MAARC) for suspected maltreatment and complete a thorough investigation for two of two residents (R9, R10) who had an altercation with each other.

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:

R9
The licensee failed to immediately report the March 19, 2023, physical altercation between R9 and R10 to MAARC.

R9's diagnoses included Huntington's disease (a disease that causes progressive breakdown of nerve cells in the brain that impacts a person's functional abilities) and schizophrenia.

R9's Vulnerability, Safety, and Risk assessment dated March 28, 2023, indicated the resident was at risk for physical abuse from others.

R9's Resident Incident Report dated March 19, 2023, indicated that R9 had been hit in the mouth three times by R10 and was bleeding from the mouth.

R9's Progress Notes dated March 19, 2023, indicated R9 had accidentally rolled over R10's feet with his wheelchair and R10 punched R9 in the mouth three times which caused R9 to bleed

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out of his mouth. R9 was able to rinse the blood out of his mouth and there was no apparent injury. R9's father was called and visited with R9 and decided not to have R9 evaluated.

R10
The licensee failed to immediately report the March 19, 2023, physical altercation between R9 and R10 to MAARC.

R10's diagnoses included degeneration of nervous system due to alcohol, major depressive disorder, heart failure, essential hypertension, and alcohol dependence.

R10's Vulnerability, Safety, and Risk assessment dated June 2, 2021, indicated R10 has had several altercations over the last month involving other residents that included punching and hitting with objects. Crisis team has been involved and stated it is behavioral not mental heath related. Nurse Practitioner (NP) updated and ordered lab work.

R10's Resident Incident Report dated March 19, 2023, indicated unlicensed staff observed R10 hitting another resident three in the face three times on camera.

R10's Progress Notes dated March 19, 2023, at 6:51 p.m., indicated R10 allegedly hit another resident in the mouth three times for accidentally running over his foot with a wheelchair. R10 did not offer an explanation or answer any questions. He denied any injuries on himself. Family and case worker notified.

R9 and R10's record both lacked evidence of this incident being reported to MAARC within 24 hours of the incident occurring.

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NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 80 On June 21, 2023, at 10:15 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the facility did not file a MAARC report on this incident, and she was unaware this incident would need to be filed. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, indicated if the Assisted Living Director or Clinical Nurse Supervisor confirm the suspicion of maltreatment, they will contact the MAARC. Such report must be made no later than 24 hours after the maltreatment was suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting	03090		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31214	A. BUILDING: ______ B. WING ______	06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAGEL ASSISTED LIVING	232 ELM STREET SOUTH WACONIA, MN 55387

(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
03090	Continued From page 81	03090		

Continued From page 81

all residents in the assisted living facility, staff, and any visitors of the licensee.

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

The findings include:

On June 20, 2023, at 10:45 a.m. during a tour of the facility, the surveyor observed the incorrect electronic monitoring notice posted at the entrance to the licensee's facility, which read: "Warning premises protected by 24 hour audio and video surveillance by entering you agree to be recorded." The surveyor observed several cameras in the hallways of the facility and a monitor located at the front desk that had views of multiple camera video surveillance playing in real time and in view of the staff behind the desk.

On June 21, 2023, 10:15 a.m., licensed assisted living director (LALD)-A stated she was unaware of the required verbiage on the electronic monitoring sign.

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *06/13/23*
Time: 09:00:00
Report: 8087231156

Food and Beverage Establishment Inspection Report

Location:
Nagel Assisted Living
232 Elm Street South
Waconia, MN55387
Carver County, 10

Establishment Info:
ID #: 0039119
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632676658
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THERE IS NO FULL TIME STATE CERTIFIED FOOD PROTECTION MANAGER AT THE ESTABLISHMENT. HIRE A FULL TIME EMPLOYEE OR TRAIN AN EXISTING FULL TIME EMPLOYEE AND APPLY FOR THE STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE.

Comply By: 08/01/23

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at -- Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 9 Degrees Fahrenheit - Location: STAND FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: COLESLAW
Temperature: 40 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: SHRIMP SALAD
Temperature: 41 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: HB EGG
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 2 Degrees Fahrenheit - Location: STORAGE FREEZER - RIGHT
Violation Issued: No

Process/Item: Ambient Air
Temperature: 22 Degrees Fahrenheit - Location: STORAGE FREEZER - LEFT
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: STORAGE STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 37 Degrees Fahrenheit - Location: STORAGE STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 37 Degrees Fahrenheit - Location: STORAGE STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: HB EGG
Temperature: 37 Degrees Fahrenheit - Location: STORAGE STAND-UP COOLER
Violation Issued: No

Process/Item: Thawing: CHICKEN
Temperature: 28 Degrees Fahrenheit - Location: STORAGE STAND-UP COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER JASON WHITE.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

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 8087231156 of 06/13/23.

Certified Food Protection Manager:________________________________

Certification Number: ______________ Expires: __/ /__________

Inspection report reviewed with person in charge and emailed.

Signed:___________________________________

JASON WHITE
KITCHEN MANAGER

Signed:___________________________________

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us