Electronically Delivered

November 1, 2022

Administrator
Carriage House Senior Living
175 East Derrynene Street
Le Center, MN 56057

RE: Project Number(s) SL35876015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 12, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that

consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

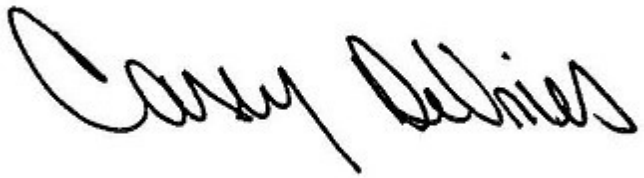
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

(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 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: SL35876015-0 On October 10, 2022, through October 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 19 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan to determine staffing levels to meet the needs of residents. 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	0 470		

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0 470	Continued From page 2	0 470		

cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 25 residents and had a current census of 19 residents.

During the entrance conference on October 10, 2022, at 11:14 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the usual staffing schedule for the facility was as follows:
- the registered nurse (RN) was on site Monday through Friday 8:00 a.m. to 4:30 p.m., and rotated the on-call schedule with the licensed practical nurse (LPN);
- the day shift was staffed with three unlicensed personnel (ULP) from 6:30 a.m. to 2:30 p.m.;
- the evening shift was staffed with three ULP from 2:30 p.m. to 10:30 p.m.; and
- the night shift was staffed with one ULP from 10:30 p.m. to 6:30 a.m.

The licensee provided an undated Long-term Care Contingency Staffing Plan template they had completed, which noted during normal conditions the number of staff required was three on the day and evening shifts and one on the night shift. However, it lacked evidence of any staffing metrics used to determine appropriate staffing levels.

On October 12, 2022, at 8:58 a.m., CNS-A stated they are doing the staffing schedule and plan, but

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0 470	Continued From page 3 do not have a written plan. In addition, she indicated they had checked with a provider group the previous week to see if they had a template to use for the staffing plan, but none was available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 4 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 October 11, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 5 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 develop a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 10, 2022, at 11:14 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP). The licensee provided an undated Hazard and Vulnerability Assessment Tool. However, they lacked an EPP to include the following: On October 12, 2022, at 2:45 p.m., the licensee's EPP was reviewed with clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B, who indicated the plan lacked the	0 680		

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0 680	Continued From page 6 following required content: - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who was authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness to maintain integrated response; - a policy and procedure to address alternate sources of energy to maintain fire detection, extinguishing, and alarm systems; - a policy and procedure to address sewage and waste disposal; - a policy and procedure to track the location of on-duty staff and residents who are relocated, to include the specific name and location of the receiving facility or other location; - a policy and procedure to shelter in place for residents, staff and volunteers who remain in the facility; - a policy and procedure to address a system of medical documentation that preserved the resident information, protected confidentiality, and secured and maintained the availability of records; - a policy and procedure to address the use of volunteers, including the process/role for integration; - a communication plan to include: - the contact information for the Minnesota Office of Ombudsman for Long-Term Care; - primary and alternate means of communicating with the facility staff and Federal, State, tribal, regional and local emergency management agencies; - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care	0 680		

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0 680	Continued From page 7 providers to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted; - means of providing information about general condition/location of residents under the facility's care - means of providing information about the facility's occupancy, needs and ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - method for sharing information from the emergency plan, that the facility had determined appropriate, with residents and their families/representatives; and - EPP training and testing program. In addition, the licensee failed to post the emergency disaster plan prominently as required. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, noted the emergency preparedness plan would include all required elements of appendix Z, including policies and procedures, a communication plan, and staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 800		

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0 800	Continued From page 8 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 staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has 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: 1. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that in the NE Wing corridor there was a hole in the ceiling tile, in the Service Office there was missing ceiling tile(s), and in General Storage closet the ceiling was missing ceiling tile(s) 2. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that in the following locations had items stacked and stored within 18 inches of the fire sprinkler head(s): Covid Storage closet; General Storage closet; and SW closets	0 800		

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0 800	Continued From page 9 3. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that the in the Kitchen area - sprinkler head(s) exhibited signs of oxidation 4. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that the Kitchen Hall emergency light did not function upon testing 5. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure observed the use of multi-tap electrical adapters in the following locations: RM 20; Directors Office; RM 16; RM 09; RM 04; and the Nurses Station 6. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that in the Maintenance Room that combustible items were being stored less than 30 inches from the fuel fired appliance 7. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that at the following exit points the egress to grade exceed vertical and horizontal dimensions: NE exit - ½ inch vertical, 2 inches slab-to-slab; SE exit - 1 inch vertical and 2nd slab in sidewalk having a 1 inch vertical; SW exit 1 inch vertical. (LALD)-B and (CNS)-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and	0 810		

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0 810	Continued From page 11 evacuation plans and associated confirming documentation. This deficient condition has 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: 1. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to confirm that fire drills and evacuation drills are being completed 2. On 10/12/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to confirm that annual resident training on evacuation procedures and protocols is being completed (LALD)-B and (CNS)-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

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0 940	Continued From page 12 (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a contract with the required content for two of two residents (R1 and R2). This had the potential to affect all 19 current residents.	0 940		

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0 940	Continued From page 13 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: The licensee failed to provide a contract to include the following required content: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the	0 940		

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0 940	Continued From page 14 housing support program. R1 R1's diagnoses included chronic systolic heart failure. R1's Assisted Living Resident Agreement identified as the contract, dated April 28, 2022, lacked the above required content. R1's Service Plan dated July 29, 2022, indicated R1 received services which included assistance with bathing and dressing, and medication management. R2 R2's diagnoses included Parkinson's disease. R2's Assisted Living Resident Agreement dated February 25, 2022, lacked the above required content. R2's Service Plan dated September 19, 2022, indicated R2 received services which included assistance with dressing, catheter cares, and medication management. On October 12, 2022, at 9:05 a.m., licensed assisted living director (LALD)-B stated the contract lacked the required content, and indicated the same contract template was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		

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0 970	Continued From page 15	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety or personal property of a resident. This had the potential to affect all 19 current residents. 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: The licensee's assisted living contract included: - Page 12, section 29. Personal Property. "You agree that Landlord is not responsible for any loss or damage to your personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Landlord's control. You are strongly encouraged to obtain renter's insurance."	0 970		

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0 970	Continued From page 16 - Page 12, section 32. Indemnification. "Resident will indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." - Page 12, section 33. Insurance. "Landlord will maintain appropriate levels and types of insurance covering the building and its contents. Because Landlord does not maintain insurance covering the contents of tenants' apartment units or garages, Resident is strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Apartment Unit, as well as any injury to Resident or Resident's guests occurring within the Apartment ("renter's insurance"). Resident acknowledges and understands that the lack of such insurance coverage may result in personal loss to and/or liability of Resident. In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against Landlord and its representatives for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such damage or destruction." - Page 12 - 13, section 34. Liability. "Landlord is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of Landlord's own negligent acts or those of its employees or agents. Landlord is also	0 970		

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0 970	Continued From page 17 not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Landlord's premises." On October 12, 2022, at 11:15 a.m., licensed assisted living director (LALD)-B stated the content was included in the contract utilized for all residents, and indicated it was done through the licensee's attorney. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care;	01060		

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01060	Continued From page 18 (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R1) hospitalized. 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	01060		

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01060	Continued From page 19 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic systolic heart failure. R1's Resident Notes noted: - July 15, 2022, resident was sent to the emergency department via ambulance for potential stroke; - July 16, 2022, resident was admitted to the hospital; and - July 20, 2022, resident returned to the facility. R1's Service Plan dated July 29, 2022, indicated R1 received services which included assistance with bathing, dressing, and medication management. R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact	01060		

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01060	Continued From page 20 information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that R1 had been relocated and had not returned to the facility within four days. On October 12, 2022, at 1:50 p.m., clinical nurse supervisor (CNS)-A stated a written notice had not been provided to the resident or representative and indicated they did not agree this was required for a hospitalization. In addition, CNS-A said the licensee had not notified the OOLTC. The licensee's Emergency Relocation policy dated August 25, 2022, noted in the event of an emergency relocation, the licensee would provide written notice to include: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC and Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal, and the facility would provide contact information for the agency to which the resident may submit an appeal. In addition, the policy noted the notice would be delivered to the OOLTC if the resident had been relocated and had not returned to the facility within four days.	01060		

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01060	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which	01440		

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01440	Continued From page 22 the individual began working for the licensee for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E's record lacked evidence to document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks as required. ULP-E started employment on February 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On October 12, 2022, at 2:12 p.m., clinical nurse supervisor (CNS)-A stated this may have been provided by a prior nurse, and indicated the employees file lacked documented evidence of the direct supervision required. The licensee's Supervision of Staff - Delegated Services policy dated August 2021 noted direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working and first performed the delegated tasks for the residents and thereafter as needed.	01440		

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01440	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following 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	01470		

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01470	Continued From page 24 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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 interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for two of two employees (clinical nurse supervisor (CNS)-A and unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01470		

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01470	Continued From page 25 or has the potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A began providing assisted living services on October 4, 2021. CNS-A's employee record lacked documented evidence of the following: - overview of Assisted Living statutes; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. ULP-E ULP-E started employment on February 21, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's employee record lacked documented evidence of the following: - overview of Assisted Living statutes; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On October 12, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated orientation on the above required content had not been provided to the licensee's staff as required with the change in regulations effective August 1, 2021. The licensee's Orientation of Staff and Supervisors & Content policy dated August 2021 noted all staff must complete the orientation to assisted living facility requirements before	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

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01470	Continued From page 26 providing services to the residents. It also noted the orientation must contain an overview of the assisted living statutes and a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about	01690		

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01690	Continued From page 27 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the entrance conference on October 10, 2022, at approximately 11:14 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services to the licensee's residents. The licensee lacked the following required policy: - verifying that prescription drugs were administered as prescribed. On October 12, 2022, at 11:10 a.m., CNS-A	01690		

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01690	Continued From page 28 stated she was unable to locate the above required policy. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01690		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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01700	Continued From page 29 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) conducted an individualized assessment with the required content for two of four residents (R5 and R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 10, 2022, at 11:14 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to their residents. R5 and R6's records lacked evidence the RN conducted a medication assessment to include allergic or adverse reactions and actions to address these issues. On October 11, 2022, at approximately 8:11 a.m. and 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-E set up medications to administer to R6 and R5, respectively. The bubble pack noted "CAUTION: HAZARDOUS DRUG OBSERVE SPECIAL HANDLING, ADMINISTRATION AND DISPOSAL REQUIREMENTS". When asked at this time what the precautions were, ULP-E stated she	01700		

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01700	Continued From page 30 was not sure. R5 R5's diagnoses included dementia. R5's prescriber orders dated February 25, 2022, included spironolactone 25 milligrams (mg) by mouth once daily. R5's Service Plan dated March 14, 2022, noted services including assistance with dressing, grooming, and medication management. R5's Assessment As Of Date dated September 1, 2022, noted "Resident takes spironolactone for hypertension (diuretic)." The assessment also included a section titled for specific instructions on how the medication was to be given. It noted "Resident does have a complex medication regimen due to the number of medications she takes. She receives medications multiple times a day, some of which are topical. She takes her medication whole and never refuses her medications. Resident is having cataract surgery this month, which will increase the complexity of her medication with the addition of eye drops." However, the assessment lacked any mention of a hazard related to the medication. R5's October 2022 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. R6 R6's diagnoses included acute combined systolic and diastolic heart failure. R6's prescriber orders dated May 19, 2022, included spironolactone 25 mg by mouth daily.	01700		

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01700	Continued From page 31 R6's Assessment As Of Date dated August 26, 2022, noted "Resident takes furosemide and spironolactone daily." It also included a section titled for specific instructions on how the medication was to be given. It noted "Resident's medication regimen is complex due to the number of medications and multiple times they are given. He receives medications three times daily with no special administration needs." R6's Service Plan dated August 30, 2022, noted services including assistance with walking, transferring, and medication management. R6's October 2022 Med Admin Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. On October 11, 2022, at 8:55 a.m. CNS-A stated she was not aware of the caution sticker on the front of R5 and R6's medication card for the spironolactone or of any special precautions, but would check with the pharmacy on this. At 9:16 a.m., CNS-A stated the pharmacy informed her staff were to wear gloves when they administer the medication, and wear double gloves if they crushed or handled the medication. The licensee's "Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, noted the assessment must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

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01700	Continued From page 32 days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to	01790		

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01790	Continued From page 33 be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	01790		

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01790	Continued From page 34 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 the entrance conference on October 10, 2022, at 11:14 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management to the licensee's residents. The licensee's Medication Management - Planned Unplanned Time Away policy dated August 2021 noted for unplanned resident time away when a pharmacist or licensed nurse is not available, the RN could delegate the task to the unlicensed personnel (ULP) if the RN had developed written procedures to address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - the written information about the medications to be given to the resident or resident's representative; - how the ULP must document in the resident's record that medications had been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information; - how the RN should be notified that medications had been given to the resident or resident's representative and whether the RN needed to be contacted before the medications were given to the resident or resident's representative;	01790		

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01790	Continued From page 35 - a review by the RN of the completion of this task to verify the task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication. The licensee's Medication Sent out of the Facility form lacked instruction to include: - how the ULP must document in the resident's record any unused medications that had been returned to the provider, including the name of each medication and the doses of each returned medication. On October 12, 2022, at 8:55 a.m., CNS-A stated the form lacked the required instruction noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:	01940		

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	35876	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

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01940	Continued From page 36 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content, and failed to include a written statement in the service plan of the treatment or therapy service being provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 37 The findings include: During the entrance conference on October 10, 2022, at 11:14 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to residents. R1's record lacked a treatment management plan to include: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatment or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent complications or adverse reactions. In addition, the service plan lacked identification of the low sodium diet. R1 R1's diagnoses included chronic systolic heart failure. R1's prescriber orders dated May 2, 2022 included an order for a low sodium diet. R1's Modifications to the Service Plan dated July 29, 2022, indicated R1 received services which included a mechanical soft diet and meal	01940		

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01940	Continued From page 38 assistance. However, the plan lacked identification of the low sodium diet. R1's Assessment As Of Date dated July 25, 2022, noted the resident had a low sodium diet and frequently declined breakfast. In addition, the assessment noted "No treatments and Therapies/Self-manages." On October 12, 2022, at 1:50 p.m., CNS-A stated the resident's record lacked a treatment management plan to include the ordered specialized diet, and indicated she was not aware the diet was considered a treatment. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, noted the treatment management plan would include a statement of the type of services that would be provided. The policy also noted the licensee would include in the service plan a written statement of the treatment or therapy services that would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of	02110		

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02110	Continued From page 39 person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that 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, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents. This practice resulted in a level two violation (a	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 40 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee had an Assisted Living with Dementia Care license, dated August 1, 2022, and was licensed for a bed capacity of 25 residents. On October 10, 2022, at 2:45 p.m., licensed assisted living director (LALD)-B stated the inclusive list of dementia care policies had not been provided to each resident and/or representative, and indicated she was not aware of the requirement to do so. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

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CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

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02170	Continued From page 41 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 conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1 and	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

(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
02170	Continued From page 42 R2) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 25 residents and had a current census of 19 residents. R1 and R2's records included an evaluation to include past and current interests, current abilities and skills, emotional and social needs and patterns, and identification of activities for behavioral interventions. However the records lacked: - physical abilities and limitations; and - adaptations necessary for the resident to participate. In addition, the records lacked an individualized activity plan based on the activity evaluation that reflected the residents' activity preference and needs. R1 R1's diagnoses included chronic systolic heart failure. R1's Service Plan dated July 29, 2022, indicated R1 received services which included assistance	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35876	A. BUILDING: _____ B. WING _____	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	175 EAST DERRYNENE STREET LE CENTER, MN 56057

(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
02170	Continued From page 43 with bathing and dressing, and medication management. R1's Assessment As Of Date dated July 25, 2022, noted the resident enjoyed watching football, visiting with family, cards, and going out to eat. However, it lacked the above required content. R2 R2's diagnoses included Parkinson's disease. R2's Service Plan dated September 19, 2022, indicated R2 received services which included assistance with dressing, catheter cares, and medication management. R2's Assessment As Of Date dated September 30, 2022, noted the resident enjoyed talking with others and making jokes, sports and math. However, it lacked the above required content. On October 12, 2022, at 1:50 p.m., clinical nurse supervisor (CNS)-A stated the above required content was missing and said the same format was utilized for all residents. The licensee's Live Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, noted each resident must be evaluation for activities according to the licensing rules of the facility, and the evaluation must address the physical abilities and limitations and adaptations necessary for the resident to participate. It also noted an individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02170	Continued From page 44 (21) days	02170		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *10/11/22*
Time: 13:35:01
Report: 7962221201

Food and Beverage Establishment Inspection Report

Location:
Carriage House Senior Living
175 East Derrynene Street
Le Center, MN56057
Le Sueur County, 40

Establishment Info:
ID #: 0038080
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073570100
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.

5-200B Plumbing: cross connections
5-203.14 ** Priority 1 **
MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

MOP SINK FAUCET DOES NOT HAVE BACKFLOW PROTECTION
Comply By: 10/18/22

5-200B Plumbing: cross connections
5-203.14A ** Priority 1 **
MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

WATER SOFTENER DISCHARGE LINE, AIRGAP DOCUMENT SENT WITH REPORT
Comply By: 10/18/22

5-200C Plumbing: Maintenance, fixture location
5-205.13 ** Priority 2 **
MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

RPZ BACKFLOW DEVICE ON BOILER LAST INSPECTED AUGUST 2020, RPZ IS REQUIRED TO BE INSPECTED YEARLY
Comply By: 10/18/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

PROVIDE DOCUMENTATION THAT THE PORTABLE ICE MACHINE, IGLOO ICE103, IS TO THE ANSI SANITATION STANDARD, PICTURE OF MANUFACTURERS LABEL AND FACT SHEET SENT WITH REPORT, REMOVE CROCKPOT FROM FACILITY

Comply By: 10/18/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

SPACE BETWEEN BOTTOM CUPBOARD AND SINK NOT CAULKED

Comply By: 10/18/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF POPCORN MACHINE GREASY AND FOOD DEBRIS

Comply By: 10/12/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

CAULK ON RIGHT OF SCRAP SINK MOLDY, SPACE BETWEEN BOTTOM CUPBOARD AND SINK MOLDY

Comply By: 10/18/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 190 Degrees Fahrenheit
Location: RINSE TEMPERATURE, THERMOMETER ON MACHINE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Hot Water: = at 170 Degrees Fahrenheit
Location: MAX/MIN THERMOMETER SENT THROUGH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: NOODLES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: CHICKEN NOODLE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	4

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 7962221201 of 10/11/22.

Certified Food Protection Manager: Teresa Bruley

Certification Number: FM110729 Expires: 04/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Teresa Bruley
Director of Food Service

Signed: Heather Flueger
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us