



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 15, 2023

Licensee

Villa Vista And Cardinal Court

1220 Villa Court Drive

Cromwell, MN 55726

RE: Project Number(s) SL30721015

Dear Licensee:

On November 7, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 24, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 24, 2023, found not corrected at the time of the November 7, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - \$500.00

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 7, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on November 7, 2023, we identified the following violation(s):

0650-Employee Records-144g.42 Subd. 8

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to

comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@stae.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/07/2023
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30721015 On November 7, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 24, 2023. At the time of the survey, there were 49 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were issued and reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	{0 470}			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 470}	Continued From page 1 (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: No further action required.	{0 470}			
0 650 SS=D	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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0 650	Continued From page 2 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 interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP)-G's employee record contained documentation pertaining to demonstrating competency of the Libre Blood Glucose Monitor ULP-B performed. 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:	0 650			

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0 650	Continued From page 3 ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On November 7, 2023, at 9:30 a.m., ULP-G stated she performed R1's blood glucose monitoring using the Libre Blood Glucose Monitor daily. ULP-G stated a previous registered nurse (RN) trained ULP-G on the Libre Blood Glucose Monitor when R1 started using the Libre Blood Glucose Monitor. ULP-G's employee record lacked documentation of ULP-G receiving training and demonstrating competency on the Libre Blood glucose Monitor. On November 7, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated ULP-G had been trained by a previous RN who no longer works for the licensee and stated could not find documentation of the training. The licensee's Personnel Records policy revised August 5, 2021, indicated at a minimum the following documents: competency evaluations will be in the employees record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	{0 660}			

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{0 660}	Continued From page 4 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed ensure a TB Risk Assessment was completed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2023, at 9:30 a.m., the surveyor requested a copy of the TB risk Assessment for review. On November 7, 2023, at 10 :23 a.m., licensed	{0 660}			

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{0 660}	Continued From page 5 assisted living director (LALD)-A stated they had not completed a TB Risk Assessment.. The licensee's Communicable Disease Policy: Tuberculosis Prevention and Control policy last reviewed June 2017, indicated a annual TB Risk Assessment will be completed. No further information was provided.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}			

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{0 680}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all 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: On November 7, 2023, at approximately 10:00 a.m., during a self-guided tour of the facility, the surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. On November 7, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A provided a three ring binder titled "Assisted Living EPP". LALD-A stated she received the binder from a provider organization. The binder contained a template for the EPP, but the template was not individualized for the facility. The licensee's undated EPP lacked the following content and/or policies and procedures to address: - a risk assessment considering hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks,	{0 680}			

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{0 680}	Continued From page 7 loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - a description of the population served by the licensee to identify at risk populations; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - shelter in place to meet the needs of the residents; - fully developed evacuation plan; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; - the facility's role in providing care and treatment at alternative sites; - missing persons policy that was reviewed quarterly; and -written arrangements with other facilities or providers. In addition, the licensee lacked a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; and - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On November 7, 2023, at 11:00 a.m., LALD-A	{0 680}			

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{0 680}	Continued From page 8 stated she had not updated the facilities EPP to include the above information. No further information was provided.	{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 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: No further action required.	{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 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	{0 810}			

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{0 810}	Continued From page 9 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: No further action required.	{0 810}			
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	{0 900}			

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{0 900}	Continued From page 10 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written assisted living contract, with the required content in a resident record for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3's diagnoses included diabetes type II and hypertension (high blood pressure). R3's Medication/Treatment Plan/Therapy	{0 900}			

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{0 900}	Continued From page 11 Management Plan dated January 6, 2015, indicated R3 received the following services: medication management and blood glucose monitoring. R3's November 2023 medication administration record (MAR) indicated R3 received assistance with medication administration daily. R3's record contained a signature page of the contract dated July 17, 2021; however, lacked an original or copy of the licensee's contract with all the required content. On November 7, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated she was unable to find R3's contract in R3's record. No other information was provided.	{0 900}			
{01470} SS=D	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	{01470}			

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{01470}	Continued From page 12 and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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:	{01470}			

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{01470}	Continued From page 13 Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (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 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-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R1's November 2023 medication administration record (MAR) indicated ULP-G assisted R1 with medication administration on several days. ULP-G's employee record lacked evidence ULP-G had completed the following training: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and	{01470}			

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{01470}	Continued From page 14 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 7, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated ULP-G had not completed the above components of Assisted Living Orientation. The licensee's Staff competency Training and evaluation policy revised August 4, 2021, indicated the orientation must include the following topics; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided.	{01470}			
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must	{01530}			

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{01530}	Continued From page 15 have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-F, registered nurse (RN)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01530}			

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{01530}	Continued From page 16 The findings include: ULP-F ULP-F was hired on October 4, 2022, to provide direct care services. R1's October 2023 medication administration assessment (MAR) indicated ULP-F had assisted R1 with medication administration on several occasions. ULP-F's employee record indicated ULP-F received two hours of dementia training on February 22, 2023. ULP-F's employee record lacked evidence ULP-F six hours of dementia training. RN-C RN-C started employment on May 2, 2023, to provide supervision and direct care services to the residents. RN-C's employee record lacked evidence RN-C completed eight hours of dementia training. On November 7, 2023, at 1:00 p.m. clinical nurse supervisor (CNS)-B provided the surveyor 2023 annual training. CNS-B stated RN-C and ULP-F's employee records lacked evidence ULP-F and RN-C had completed eight (8) hours of dementia training. CNS-B stated RN-C and ULP-F had worked more than 120 hours. The licensee's undated Dementia Training policy indicated direct care staff must have a minimum of eight (8) hours of dementia training. The policy does not address annual training. No further information was provided.	{01530}			

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{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) reassessed two of two residents with change of condition (R3, R9), and failed to ensure the RN assessed one of one resident (R9) with chair or floor alarms. 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	{01620}			

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{01620}	Continued From page 18 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: CHANGE OF CONDITION R3 R3's Care Plan dated May 30, 2023, indicated R3 received assistance with medication administration, bathing dressing, grooming, bed mobility, transfers, toileting, housekeeping and laundry. R3's Resident/Visitor Unusual Occurrence Report, dated October 26, 2023, (written by a unlicensed personnel (ULP)) indicated R3 had an area on R3's chest that is now open. Area cleansed. Bacitracin and opsite applied. The area entitled Nurse Manager Review was blank. R3's Medical Referral Form dated October 31, 2023, indicated the resident had a large boil on right upper breast. The physician ordered Augmentin (antibiotic) 875 mg (milligrams) twice a day times ten days. R3's Progress Notes indicated the following (written by ULP): -October 26, 2023, Resident has an area on middle of chest that was a boil looking bump. The area opened this afternoon. Cleansed area with Bacitracin and opsite applied. Will notify the RN to look at in the morning. Area is a 3 cm (centimeter) in diameter. The outer area is red. R3's Uniform Assessment Tool was dated August 29, 2023.	{01620}			

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{01620}	Continued From page 19 R3's record lacked evidence the RN had reassessed R3's change of condition pertaining to open area on R3's chest. R9 R9's diagnoses include hypertension (high blood pressure) and depression. R9's Medical Transport Report dated September 29, 2023, (written by ULP) indicated R9 was found on the floor in R9's bedroom by his bed. R9 was bleeding on the back of his head. Ambulance was called. Vital signs were BP (blood pressure) 121/74, pulse 74, temperature 98.1, and oxygen saturation 98. Family was notified. Left by ambulance at 2305 (11:05 p.m.). R9's Medical Referral Form dated September 30, 2023, indicated physician examination completed. R9 had a V shaped flap laceration to posterior scalp, right of midline. Repaired with Dermabond. (topical adhesive). Monitor for any signs or symptoms of local infection. Follow up for any concerns. R9's Progress Notes (written by ULP) indicated: -September 29, 2023, at 2325 (11:25 p.m.), R9 was found on the floor in his bedroom. R9 was bleeding from the back of R9's head. R9 was sent to the hospital. Family and Hospice were notified. -September 30, 2023, at 2:00 a.m., R9 returned from the hospital via ambulance at 1:45 a.m. R9 was put into bed. The open area on back of R9's head was "glued shut". Monitor for infection. R9's Uniform Assessment Tool was dated September 7, 2023. R9's record lacked evidence the RN had	{01620}			

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{01620}	Continued From page 20 reassessed R9's change of condition pertaining to the fall with a laceration. On November 7, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated she was aware of R3's open area on R3's chest and the laceration on R9's head. CNS-B stated R3 and R9's records lacked documentation the RN had assessed the changes in the residents condition as indicated above. CNS-B checked her office and was unable to find any documentation pertaining to the above. ASSESSMENT OF ALARMS R9 On November 7, 2023, at 11:30 a.m., R9 was observed in the dining room, sitting in a wheelchair with a chair alarm attached to R9's shirt. R9's Individual Abuse Prevention Plan Assessment dated September 7, 2023, indicated R9 was unable to call for help or use the call light due to dementia and had a alarm mechanism. R9's Care Plan dated June 16, 2023, indicated R9 had a Tabs alarm. R9's November 2023, Daily Service Delivery Record indicated R9 was monitored three times a day for the use of a Tabs alarm. R9's Uniform Assessment Tool dated September 7, 2023, indicated R9 had dementia, was wheelchair bound, at risk for falls, leaning forward in wheelchair, non ambulatory, and required two persons assist with transfers. R9's assessment did not indicate R9 required the use of a Tabs alarm and lacked an assessment to determine the appropriate use.	{01620}			

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{01620}	Continued From page 21 On November 7, 2023, at 2:00 p.m., CNS-B stated R9 was not able to use the call light, would lean forward in his wheelchair, and at risk for falls. CNS-B stated when needed she puts on the chair alarms for safety and does not complete an assessment pertaining to the chair alarms. The licensee's Uniformed Nursing Assessments policy dated August 11, 2022, indicated for the 14 day assessment and assessments after falls, injuries, ER (emergency room) visits and other needs will be completed as a Focused Assessment. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2. Nursing Assessment. A. A nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided.	{01620}			

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{01650}	Continued From page 22	{01650}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for five of five residents (R1, R2, R3, R4, R9). This practice resulted in a level two violation (a	{01650}			

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{01650}	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3, R4 and R9's Service Plans lacked the following required content: -a description of the service to be provided; -the frequency of each service; and -the identification of staff or categories of staff who will provide the service. R1 R1's diagnoses included Parkinson's disease and diabetes. R1's November 2023, Service Delivery Record indicated R1 received assistance with medication administration, dressing, grooming, toileting, laundry, and housekeeping. On November 7, 2023, at 11:30 a.m., the surveyor observed R1 walking to the dinning room with R1's wife. R2 R2's diagnoses included coronary artery disease (CAD). R2's November 2023 Service Delivery Record indicated R2 received assistance, with medication administration, bathing, dressing, grooming, mobility, toileting, transfer, laundry and housekeeping. services included assistance with bathing, medication administration, oxygen	{01650}			

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{01650}	Continued From page 24 management, and laundry. On November 7, 2023, at 9:40 a.m., the surveyor observed R2 sitting in wheelchair in R2's room. R3 R3's diagnoses included diabetes type II and dementia. R3's November 2023, Service Delivery Record indicated R3 received assistance with dressing, grooming, toileting, bathing, housekeeping, safety checks and monitoring in mobility and ambulation. On November 7, 2023, at 11:30 a.m., the surveyor observed sitting in wheelchair in dinning room. R4 R4's diagnoses included dementia, macular degeneration, depression disorder, hypertension (high blood pressure). R4's November 2023, Service Delivery Record indicated R4 received assistance with dressing, grooming, bed mobility, transferring, toileting, bathing, housekeeping and safety checks. On November 7, 2023, at 11:30 a.m., the surveyor observed eating lunch in the dining room. R9 R9's diagnoses included hypertension and depression. R9's November 2023, Service Delivery Record indicated R9 received assistance with dressing, grooming, eating, transfers, bed mobility, toileting,	{01650}			

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{01650}	Continued From page 25 bathing, housekeeping and safety checks. On November 7, 2023, at 11:30 p.m., the surveyor observed R9 sitting in wheelchair with chair alarm attached in the dining room. On November 7, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated R1, R2, R3, R4, R9's and all other resident's services plans had not been updated to include a description of the service to be provided; the frequency of each service; and the identification of staff or categories of staff who will provide the service. CNS-B stated they were working with [name of computer documentation company] to get the resident information entered into the computer, assessments completed, and then they will complete a new service plan for the residents. The licensee's Service Plan policy dated 2008, indicated the service plan would include the following: - a description of the service to be provided; - the frequency of each service; and - the identification of staff or categories of staff who will provide the service. No further information was provided.	{01650}			
{01790} SS=E	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	{01790}			

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{01790}	Continued From page 26 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 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	{01790}			

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{01790}	Continued From page 27 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 observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-D, ULP-F, ULP-G) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all forty-nine 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On November 7, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to all residents and ULP would prepare and send	{01790}			

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{01790}	Continued From page 28 medications with the residents for unplanned times away. ULP-D ULP-D started employment on November 18, 2002, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R1's November 2023 medication administration record (MAR) indicated ULP-D administered medications to R1 on several occasions. ULP-F ULP-F was hired on October 4, 2022, to provide direct care services. On November 7, 2023, at 11:30 a.m., the surveyor observed ULP-F administer medications to several residents. ULP-G ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R1's November MAR indicated ULP-G administered medications to R1 on several occasions. ULP-D, ULP-F and ULP-G's employee records lacked evidence to indicate ULP-D, ULP-F and ULP-G had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home by an RN. On November 7, 2023, at 2:00 p.m., CNS-B stated ULP-D, ULP-F and ULP-G had not been	{01790}			

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{01790}	Continued From page 29 trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home by the RN. CNS-B knew they needed to be trained, but had not completed the training. The licensee's Medication Management for Clients Away from Facility dated March 24, 2015, did not include required training and the need for demonstrate competency to prepare and give medications for residents having unplanned time away. No further information was provided.	{01790}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 13, 2023

Licensee

Villa Vista And Cardinal Court
1220 Villa Court Drive
Cromwell, MN 55726

RE: Project Number(s) SL30721015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 24, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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

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,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2023
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30721015-0 On August 21, 2023, through August 24, 2023 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 49 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (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 ensure the staffing plan was evaluated at twice a year to ensure appropriate staffing levels. This had the potential to affect all 49 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470			

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0 470	Continued From page 2 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 Staffing, Direct-Care Staffing Plan and Daily Schedule was last reviewed on August 21, 2021. On August 24, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated the licensee's staffing plan has not been reviewed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580			

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0 580	Continued From page 3 Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all 49 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 21, 2023, at 10:00 a.m., during the entrance conference, the surveyor requested the licensee's quality management policy and documentation of quality management activity. On August 21, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A provided the licensee's policy and procedure book. The policy and procedure book did not contain a quality management policy. On August 24, 2023, at 9:45 a.m., LALD-A stated the quality management team had not met for some time and did not have any documentation of quality management activity. LALD-A stated the policy and procedure book did not contain a policy pertaining to quality management. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			

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0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed ensure a TB Risk Assessment was completed. 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:	0 660			

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0 660	Continued From page 5 TB RISK ASSESSMENT On August 21, 2023, at 10:00 a.m., during the entrance conference, the surveyor requested a TB Risk assessment from the licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. On August 24, 2023, at 10 :15 a.m., CNS-B stated she could not find the facility's TB Risk Assessment. The licensee's Communicable Disease Policy: Tuberculosis Prevention and Control policy last reviewed June 2017, indicated a annual TB Risk Assessment will be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680			

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0 680	Continued From page 6 (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 observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all 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: On August 21, 2023, at 10:13 a.m., during a self-guided tour of the facility, the surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. The licensee's emergency plan, last reviewed	0 680			

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0 680	Continued From page 7 December 2022, was provided in a three (3) ring binders titled "VCSC Policy Book". The licensee's EPP lacked the following content and/or policies and procedures to address: - a risk assessment considering hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - a description of the population served by the licensee to identify at risk populations; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - shelter in place to meet the needs of the residents; - fully developed evacuation plan; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; - the facility's role in providing care and treatment at alternative sites; - missing persons policy that was reviewed quarterly; and -written arrangements with other facilities or providers. In addition, the licensee lacked a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; and - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management	0 680			

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0 680	Continued From page 8 agencies; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On August 24, 2023, at 12:50 p.m., the surveyor reviewed the licensee's EPP with licensed assisted living director (LALD)-A and maintenance (M)-E. LALD-A stated the previous registered nurse developed the licensee's EPP and LALD-A had reviewed the plan. LALD-A stated she was in the process of creating written agreements for planned evacuation sites and transportation and had no other EPP information to provide to the surveyor. 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 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's physical environment in a continuous state of good repair	0 800			

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0 800	Continued From page 9 and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 24, 2023, at approximately 10:30 a.m. with and maintenance (M)-E it was observed that the fire-resistant rated door of resident room 105 and 203 do not self-close and latch. Fire resistant rated doors are required to automatically close and latch. It was also observed that the annual sprinkler system report indicated two deficiencies. The report indicated the dry system required 5-year inspection and 10-year required sprinkler heads located in extreme environments inspection had not been completed. Fire sprinkler systems are required to be maintained at periodic intervals. It was also observed that the fire sprinkler system exterior water flow horn strobe was damaged, and the light or horn were missing. The exterior water flow horn strobe is required to be maintained as approved at the time of installation. It was observed that a toilet was removed and the plumbing connection on the floor was sealed with duct tape in the room converted from a bathroom to storage in the old wing of the building.	0 800			

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0 800	Continued From page 10 Abandoned open plumbing connections are required to be sealed with approved plumbing fittings. It was also observed ceiling tiles were damaged and missing in the room converted from a bathroom to storage in the old wing of the building. Ceiling tiles were also missing in the old electrical room and in the corridor outside the former dining room in the old wing of building. It was observed that electrical wires and electrical conduit was hanging from the ceiling walls had been removed in the maintenance shop in the old wing of the building. Electrical wiring is required to be maintained as approved at the time of installation. These deficient conditions were visually verified by M-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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 11 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly 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 potential to affect a large portion or all of the residents). Findings include:	0 810		

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0 810	Continued From page 12 A record review of available documentation and interview were conducted on August 24, 2023, at approximately 11:45 a.m. of documents provided by licensed assisted living director (LALD)-A and 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 the licensee did not have detailed unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation indicated that employee training was not documented indicating the required sequence of once at initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training is required to be documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually.	0 810			

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0 810	Continued From page 13 Record review of the available documentation indicated that evacuation drills had been conducted on March 23, 2023, and no other documentation of fire or similar emergency evacuation drills was available. Evacuation drills for staff are required to be conducted every other month and twice per year per shift and documented separately from employee training. All deficiencies were verified by LALD-A and M-E during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900			

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0 900	Continued From page 14 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written assisted living contract, with the required content in a resident record for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R3 diagnoses included diabetes type II and hypertension (high blood pressure). R3's Medication/Treatment Plan/Therapy Management Plan dated January 6, 2015, indicated R3 the following services: medication management and blood glucose monitoring. On August 22, at 7:18 a.m., the surveyor observed ULP-D administer R3's eye drops and check R3's blood glucose at the dining table.	0 900			

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0 900	Continued From page 15 R3's record contained a signature page of the contract dated July 17, 2021; however, lacked an original or copy of the licensee's contract with all the required content. On August 24, 2023, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated she was unable to find R3's contract in R3's record and stated the original contract may have been given to the resident's representative. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
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: (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;	0 940			

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0 940	Continued From page 16 (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 observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2). This had the potential to affect all 49 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: R1 R1's assisted living contract was signed March 14, 2023. R1's July 2023, Service Delivery Record indicated	0 940			

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0 940	Continued From page 17 R1 received assistance with medication administration, dressing, grooming, toileting, laundry, and housekeeping. On August 22, 2023, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-G complete scheduled morning medication administration and blood glucose monitoring to R1. R2 R2's assisted living contract was signed July 17, 2023. R2's July 2023 Service Delivery Record indicated R2 received assistance, with medication administration, bathing, dressing, grooming, mobility, toileting, transfer, laundry and housekeeping. services included assistance with bathing, medication administration, oxygen management, and laundry. On August 22, 2023, at 8:55 a.m., the surveyor observed ULP-G complete schedule morning medication administration to R2. R1 and R2's Assisted Living contracts lacked 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. On August 24, 2023, at 9:45 a.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing from the contract and the same contract was used for all residents. No further information was provided.	0 940			

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0 940	Continued From page 18	0 940			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060			

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01060	Continued From page 19 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and 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 to one of one resident (R1), legal representative, or designated representative. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's July 2023, Service Delivery Record indicated R1 received assistance with medication administration, dressing, grooming, toileting, laundry, and housekeeping. R1's Progress Notes included the following: -May 30, 2023, R1 fell in apartment. Daughter was concerned and took R1 to the hospital. -June 1, 2023, R1 returned from the hospital.	01060			

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01060	Continued From page 20 R1's record lacked documentation R1 or R1's designated representative received an emergency relocation notice with all required content. On August 24, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-B stated R1 or R1's designated representative had not received the emergency relocation notice. CNS-B stated she was not aware of the need to give a emergency relocation notice to residents or their designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01470 SS=D	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;	01470			

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01470	Continued From page 21 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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 orientation to	01470			

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NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
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01470	Continued From page 22 assisted living statutes included all the required content for one of two employees (unlicensed personnel (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 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-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 22, 2023, at 8:00 a.m., ULP-G was observed to administer morning medications to several residents. ULP-G's employee record lacked evidence ULP-G had completed the following training: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

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01470	Continued From page 23 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 24, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated ULP-G had not completed Orientation to Assisted Living as indicated above. The licensee's Staff competency Training and evaluation policy revised August 4, 2021, indicated the orientation must include the following topics; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470			

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01470	Continued From page 24 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500			

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01500	Continued From page 25 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500			

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01500	Continued From page 26 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 an employee received all of the required annual training content for each 12 months of employment for two of five employees (unlicensed personnel (ULP)-D, 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D started employment on November 18, 2002, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 21, 2023, at 11:36 a.m., the surveyor was observed to administer afternoon medications in the dining room to several residents. ULP-D's employee record lacked evidence ULP-D completed the following required annual topics for 2022: - training on reporting of maltreatment of vulnerable adults under section 626.557;	01500			

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01500	Continued From page 27 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-G ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 22, 2023, at 8:00 a.m., ULP-G was observed to administer morning medications to several residents. ULP-G's employee record lacked evidence ULP-G had completed the following required annual training topics for 2022: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

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01500	Continued From page 28 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 24, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated ULP-D's and ULP-G's employee records lacked evidence ULP-D and ULP-G had received the above annual training in 2022. The licensee's Annual Education policy reviewed August 4, 2021, indicated the annual training would include each of the following topics: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500			

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01500	Continued From page 29 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530			

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01530	Continued From page 30 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure five of five employees (unlicensed personnel (ULP)-D, ULP-F, ULP-G, registered nurse (RN)-C) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D started employment on November 18, 2002, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 21, 2023, at 11:36 a.m., the surveyor was observed to administer afternoon	01530			

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01530	Continued From page 31 medications in the dining room to several residents. ULP-D's employee record lacked evidence ULP-D completed a minimum of two (2) hours of dementia training. ULP-F ULP-F was hired on October 4, 2022, to provide direct care services. On March 21, 2023, at 2:00 p.m., the surveyor observed ULP-F administer medications to two residents. ULP-F's employee record lacked evidence ULP-F completed eight (8) hours of dementia training. ULP-G ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 22, 2023, at 8:00 a.m. ULP-G was observed to administer morning medications to several residents. The Dementia Training Attendance Record indicated on August 10, 2022, ULP-G completed one (1) hour of Dementia training. RN-C RN-C started employment on May 2, 2023, to provide supervision and direct care services to the residents. RN-C's employee record lacked evidence RN-C	01530			

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01530	Continued From page 32 completed eight (8) hours of dementia training. On August 24, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-B provided the surveyor a copy of the August 10, 2022, Dementia Training Attendance Record. CNS-B stated the Dementia Training Attendance Record indicated ULP-D, ULP-G and M-E had only received one (1) hour of Dementia Training. CNS-B stated RN-C and ULP-F's employee records lacked evidence ULP-F and RN-C had completed eight (8) hours of Dementia training. CNS-B stated RN-C and ULP-F had worked more than 120 hours. CNS-B stated RN-C had dementia care training from her other job but did not have evidence in RN-C's employee record. The licensee's undated Dementia Training policy indicated direct care staff must have a minimum of eight (8) hours of dementia training. The policy does not address annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and	01550			

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01550	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (maintenance (M)-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: M-E was hired on June 5, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. During the survey, the surveyor observed M-E perform several maintenance tasks. The Dementia Training Attendance Record indicated on August 10, 2022, M-E completed one (1) hour of Dementia training. On August 24, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-B provided the surveyor a copy of the August 10, 2022, Dementia Training Attendance Record. CNS-B stated the Dementia Training Attendance Record indicated M-E had only received one (1) hour of Dementia Training. No further information was provided.	01550			

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01550	Continued From page 34	01550			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
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) reassessed two of two residents (R1, R2) with falls, two of two residents with change of condition (R2, R3), and failed to	01620			

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01620	Continued From page 35 ensure the RN assessed one of two residents (R4) with chair or floor alarms. 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: FALLS R1 R1's diagnoses included Parkinson's disease and diabetes. R1's July 2023, Service Delivery Record indicated R1 received assistance with medication administration, dressing, grooming, toileting, laundry, and housekeeping. On August 22, 2023, at 8:00 a.m., the surveyor observed R1 walk into the dining room using a walker, accompanied by R1's wife. R1's Resident/Visitor Unusual Occurrence Report indicated the following: - May 30, 2023, at 3:30 p.m., R1 had fallen in R1's apartment. Wife went and got staff stating resident had fallen. Staff went to apartment and found resident laying on floor. No apparent injuries Condition prior: resident was weak/faint/dizzy. Resident was unable to utilize call system. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. R1's progress notes indicated R1's daughter was	01620			

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01620	Continued From page 36 concerned and took R1 to the hospital. - June 3, 2023, at 2:00 a.m., R1 fell out of bed. He said his left eye and right ear hurt. R1 will not cooperate with neuro checks. R1 did not activate call system to seek assistance. No apparent injury, no action taken. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. -June 12, 2023, at 10:00 a.m., R1's leg buckled and R1 fell to the floor. R1 got up. No apparent injury. Resident did not activated call system to seek assistance. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. -June 13, 2023, at 11:45 a.m., R1 came in from outside and fell in the living room. Skin tear on left arm, 3 cm (centimeters) X 3 cm. Area cleansed, bacitracin and dressing applied. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. R1's Uniform Assessment Took dated March 14, 2023, fall assessment score was three (3). A score of 4 or more indicated the resident was at risk of falls. R1's Uniform Assessment Tool dated July 22, 2023, indicated R1 had falls since last assessment. R1 was at risk for falls. Does not include any interventions to prevent further falls. R1's record lacked evidence the RN reassessed R1 for causal factors and developed fall prevention plans. R2 R2's diagnoses included coronary artery disease (CAD).	01620			

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01620	Continued From page 37 R2's July 2023 Service Delivery Record indicated R2 received assistance, with medication administration, bathing, dressing, grooming, mobility, toileting, transfer, laundry and housekeeping. services included assistance with bathing, medication administration, oxygen management, and laundry. On August 22, 2022, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-G complete R2's scheduled morning medication administration. R2 was sitting in wheelchair at the dining room table with a chair alarm attached to the resident right shoulder. R1's Resident/Visitor Unusual Occurrence Report indicated the following: -May 28, 2023, at 9:45 a.m., R2 had an unobserved fall. R2 got out of her wheelchair to walk into another resident's apartment and fell. R2 had a bruise on head (left frontal). R2 did not activate call system to seek assistance. R2 does not know how to use call system. Other resident called for assistance. R2 was found on floor. Neuro checks. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. -May 28, 2023, at 4:00 p.m., R2 was found laying on the hallway floor before supper. Stated she needed to go to work. No apparent injury. Body alarm activated. Report filled out by unlicensed personnel. Area for nurse manager signature was blank. The RN assessment segment was blank. R2's Progress Notes indicated the following (written by unlicensed personnel): -May 28, 2023, R2 took a fall today. We put a tab alarm on her wheelchair so we know when she tries to get up.	01620			

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01620	Continued From page 38 -May 28, 2023, R2 took a second fall this afternoon, before supper. R2 was found laying in hallway. R2's Uniform Assessment Tool dated April 19, 2023, fall assessment score was seven (7). A score of 4 or more indicated the resident was at risk of falls. R2's Uniform Assessment Tool dated July 23, 2023, continues to be a high risk of falls. Does not include interventions to prevent further falls. R1's record lacked evidence the RN reassessed R3 for causal factors and developed fall prevention plans. On August 24, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated R1 and R2's falls address above had not been reassessed by the RN for causal factors and development of fall prevention plans. CHANGE OF CONDITION R2 R2's July 2023 Service Delivery Record indicated R2 received assistance with bathing, dressing, grooming, mobility, toileting, transfer, laundry and housekeeping. services included assistance with bathing, medication administration, oxygen management, and laundry. R2's Progress Notes indicated the following (written by unlicensed personnel): -June 12, 2023, Hospice ordered Bactrim DS 800 mg (milligrams)-160 mg for UTI (urinary tract infection) for seven (7) days. Urine is still cloudy and R2 reports burning. R2's record lacked evidence the RN had	01620			

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01620	Continued From page 39 reassessed R2 change of condition pertaining to UTI. On August 24, 2023, at 10:15 a.m., CNS-B stated the RN had not reassessed R2's change of condition pertaining to UTI. R3 R3's diagnoses included diabetes type II and dementia. R3' s Uniform Assessment Tool dated April 20, 2023, indicated R3's assessment was completed face to face, R3's diabetes type II was stable and required no treatments, R3 had no medications changes since last review and no changes in activities of daily living (ADLs), care plan or service plan. R3's prescriber orders indicated the following: -May 5, 2023, indicated R3 started metformin ER 500 milligrams (mg) daily and blood glucose monitoring daily for 10 days. -May 27, 2023, indicated R3's metformin was increased to 500 mg twice daily. -July 18, 2023, indicated R3's metformin was increased to 1000 mg twice a day and R3 received blood glucose monitoring daily. On August 22, 2023, at 7:18 a.m., the surveyor observed ULP-D check R3's blood glucose at the dining table. R3's August 2023, MAR indicated R3 received daily blood glucose monitoring effective May 2023, and metformin 1000 mg effective 7/2023. R3's Care Plan dated May 2, 2022, indicated R3 received assistance with blood glucose monitoring.	01620			

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01620	Continued From page 40 R3's Uniform Assessment Tool dated July 20, 2023, indicated R3's assessment was completed face to face and telecommunication with R3's son and there were no changes since last assessment completed on April 20, 2023. The RN failed to address changes in R3's Uniform Assessment Tool completed July 20, 2023, to reflect the following changes: -daily blood glucose monitoring and the use oral medications for diabetes management; and -medications changes to include metformin. On August 24, 2023, at 10:19 a.m., CNS-B reviewed R3's Uniform Assessment Tools and stated R3's Uniform Assessment Tool dated July 17, 2023, was not current and did not reflect multiple medications changes in R3's metformin, and daily blood glucose monitoring for diabetes management. ASSESSMENT OF ALARMS R4 R4's diagnoses included dementia, macular degeneration, depression disorder, hypertension (high blood pressure). On August 22, 2023, at 9:44 a.m., the surveyor observed ULP-D and ULP-J transfer R4 from the wheelchair to the toilet with the use of a mechanical lift. The surveyor observed a mat on floor tucked under R4's bed and a Tabs alarm on the back of R4's wheelchair with an attached string clipped to the back of R4's shirt. R4's Individual Abuse Prevention Plan assessment dated May 30, 2023, indicated R4 did not know how to use the call light and had a Tabs alarm (features a pull-string that attaches magnetically to the alarm with garment clip to the	01620			

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01620	Continued From page 41 resident) in place at on at all times. R4's Care Plan dated May 30, 2023, indicated R4 had a Tabs alarm and a mat on the floor. R4's August 2023, Daily Service Delivery Record indicated R4 was monitored three times a day for the use of a Tabs alarm and floor mat. R4's Uniform Assessment Tool dated February 2, 2023, and May 30, 2023, indicated R4 had dementia, was wheelchair bound, at risk for falls, and required two (2) persons assist with the use of a mechanical lift. R4's assessment did not indicate R4 required the use of mat on the floor and a Tabs alarm and lacked an assessment to determine the appropriate use. On August 24, 2023, at 10:19 a.m., CNS-B reviewed R4's Uniform Assessment Tools and verified the assessments did not include the use of a Tabs alarm or floor mat and stated R4 was unable to use a call light so a Tabs alarm was being used instead. CNS-B stated a Tabs alarm was not an appropriate replacement for a call light. CNS-B further stated R4 had a history of attempting to self-transfer so the Tabs alarm would alert staff if R4 was moving. CNS-B stated R4 no longer attempted to self-transfer and the Tabs alarm should be removed. The licensee's Uniformed Nursing Assessments policy dated August 11, 2022, indicated for the 14 day assessment and assessments after falls, injuries, ER (emergency room) visits and other needs will be completed as a Focused Assessment. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2. Nursing	01620			

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01620	Continued From page 42 Assessment. A. A nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650			

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01650	Continued From page 43 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3 and R4's Service Plans lacked the following required content: -a description of the service to be provided; -the frequency of each service; and	01650			

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01650	Continued From page 44 -the identification of staff or categories of staff who will provide the service. R1 R1's diagnoses included Parkinson's disease and diabetes. R1's July 2023, Service Delivery Record indicated R1 received assistance with medication administration, dressing, grooming, toileting, laundry, and housekeeping. On August 22, 2023, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-G complete scheduled morning medication administration and blood glucose monitoring to R1. R2 R2's diagnoses included coronary artery disease (CAD). R2's July 2023 Service Delivery Record indicated R2 received assistance, with medication administration, bathing, dressing, grooming, mobility, toileting, transfer, laundry and housekeeping. services included assistance with bathing, medication administration, oxygen management, and laundry. On August 22, 2022, at 8:40 a.m., the surveyor observed ULP-G complete R2's scheduled morning medication administration. R2 was sitting in wheelchair at the dining room table with a chair alarm attached to the resident right shoulder. On August 22, 2023, at 8:55 a.m., the surveyor observed ULP-G complete schedule morning medication administration to R2.	01650			

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01650	Continued From page 45 R3 R3's diagnoses included diabetes type II and dementia. R3's August 2023, Service Delivery Record indicated R3 received assistance with dressing, grooming, toileting, bathing, housekeeping, safety checks and monitoring in mobility and ambulation. On August 22, 2023, at 7:18 a.m., the surveyor observed ULP-D monitor R3's blood glucose in the dining room. R4 R4's diagnoses included dementia, macular degeneration, depression disorder, hypertension (high blood pressure). R4's August 2023, Service Delivery Record indicated R4 received assistance with dressing, grooming, bed mobility, transferring, toileting, bathing, housekeeping and safety checks. On August 22, 2023, at 7:23 a.m., the surveyor observed ULP-D administer R4's morning medications in the dining room. On August 24, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, R3 and R4's services were listed on the service delivery record and were not included on R1, R2, R3, R4 and all other resident's service plans. CNS-B stated the service delivery records were not provided to the residents and or resident's representatives. The licensee's Service Plan policy dated 2008, indicated the service plan would include the following: - a description of the service to be provided;	01650			

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01650	Continued From page 46 - the frequency of each service; and - the identification of staff or categories of staff who will provide the service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel ((ULP)-D, ULP-G) documented medication administration after administering medication to residents. In addition, the licensee failed to ensure as needed (PRN) medications were administered as prescribed and had documentation of effectiveness after administration for one of four residents (R3).	01760			

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01760	Continued From page 47 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 On August 21, 2023, at 11:36 a.m., the surveyor observed ULP-D take a stack of prefilled medication cups from the Assisted Living Plus medication cart and walk around the dining room handing out the medication cups to the residents who had medications due at noon time, one resident right after the other. ULP-D did not document in the medication administration record (MAR) after each medication was administered to the residents in the dining room. The MAR was not on the medication cart at the time ULP-D administered medications to the resident in the dining room. At 11:41 a.m., the surveyor observed the MAR on the desk at the Assisted Living Plus nurse's station. The surveyor reviewed the MAR for that day and no resident medications administered for the morning or afternoon of August 21, 2023, were signed off by ULP-D. At 2:10 p.m., ULP-D was observed documenting in the MAR medications administered during her shift and stated she usually documented in the MAR medications administered around 2:00 p.m., when it was less busy. ULP-G August 22, 2023, at 7:05 a.m., the surveyor	01760			

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01760	Continued From page 48 observed ULP-G take seven (7) initialed medications cups from the medication cart and stack the medications cups one on top of the other. ULP-G walked up to the second floor in Cardinal Court and administer the medications to the seven (7) residents in their apartments. ULP-G did not document the administration of medications after administering the medications to the residents. ULP-G went back down stair. At 7:40 a.m. ULP-G pushed the medication cart to outside the Cardinal Court dining room. ULP-G removed initialed medication cups from the top drawer of the medication cart and administer the medications to the residents in the dining room. ULP-G did not document the administration of medications after administering the medications to the residents in the dining room. ULP-G stated she documents the administration of medications on the resident's MAR (medication administration record) after she has completed administering the resident's morning medications. On August 24, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated ULPs should document medication administration after the ULP administers to the resident. The licensee's Documentation of Medication Reminders, Assistance, and Administration policy revised August 5, 2021, indicated documentation of a medication reminder, medication assistance or medication administration will be completed immediately after that task has been performed. NOT FOLLOWING PRESCRIBED ORDERS/PRN FOLLOW UP R3's diagnoses included constipation, diabetes type II and hypertension (high blood pressure).	01760			

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01760	Continued From page 49 R3's Standing Orders dated January 3, 2023, included orders for Immodium two (2) milligram capsules, give two (2) capsules after first stool, and then one capsule after each stool. Not to exceed a total for six (6) capsules in 24 hours. R3's August 2023, medication administration record (MAR) indicated R3 was administered the following medication: -Immodium one tablet seven (7) times for loose instead of the two (2) capsules as prescribed after first loose stools from August 1 to August 21, 2023; and missed 7 out of 7 opportunities for documenting follow up to determine effectiveness of PRN medication administered. On August 22, 2023, at 1:58 p.m., ULP-D stated administration of PRN medications was documented on the back of the resident's MAR required follow up within an hour after administered. On August 24, 2023, at 1: 00 p.m., the surveyor reviewed R3's August MAR and PRN Immodium administered with CNS-B and CNS-B verified the back of R3's MAR lacked documentation of follow up after PRN Immodium was administered. CNS-B stated staff were expected to document the effectiveness of any PRN medication within an hour after the medication was administered. The licensee's Medication Administration policy dated August 5, 2021, indicated the effectiveness of PRN medications was to be documented within an hours after the medication was administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01790 SS=E	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 be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been	01790			

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01790	Continued From page 51 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 observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-D, ULP-F, ULP-G) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all forty-nine (49) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01790			

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01790	Continued From page 52 situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 21, 2023, 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to all residents and ULP would prepare and send medications with the residents for unplanned times away. ULP-D ULP-D started employment on November 18, 2002, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 21, 2023, at 11:36 a.m., the surveyor was observed to administer afternoon medications in the dining room to several residents. ULP-F ULP-F was hired on October 4, 2022, to provide direct care services. On March 21, 2023, at 2:00 p.m., the surveyor observed ULP-F administer medications to two residents. ULP-G ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On August 22, 2023, at 8:00 a.m. ULP-G was observed to administer morning medications to several residents. ULP-D, ULP-F and ULP-G's employee records	01790			

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01790	Continued From page 53 lacked evidence to indicate ULP-D, ULP-F and ULP-G had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home by an RN. On August 24, 2023, at 10:15 a.m., CNS-B stated ULP-D, ULP-F and ULP-G had not been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home by the RN. The licensee's Medication Management for Clients Away from Facility dated March 24, 2015, did not include required training and the need for demonstrate competency to prepare and give medications for residents having unplanned time away. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator	01880			

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01880	Continued From page 54 temperatures for one of two medication refrigerators. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 21, 2023, at 3:18 p.m., the surveyor observed the medication refrigerator on the Assisted Living Plus (ALP) with ULP-D and verified the internal thermometer indicated 40 degrees Fahrenheit (F) and there was one (1) unopened Lantus Solostar insulin pen (long-acting insulin). On August 24, 2023, at 10:19 a.m., the surveyor reviewed the medication refrigerator temperature logs for ALP unit for June, July, and August 2023, with clinical nurse supervisor (CNS)-B and CNS-B verified the medication refrigerator temperature logs indicated the range of the medication refrigerator should be between 35-46 degrees F and indicated the following: -June 2023, temperature log contained 26 of a possible 31 temperatures recorded and 15 temperatures were below 35 degrees F. -July 2023, temperature log contained 26 of a possible 31 temperatures recorded and eight (8) temperatures were below 35 degrees F. -August 2023, temperature log contained 18 of a possible 21 temperatures recorded and 10	01880			

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01880	Continued From page 55 temperatures were below 35 degrees F. CNS-B further stated staff on the morning shift should be monitoring and recording the medication refrigerator temperatures daily and if out of range should adjust temperature dial or notify maintenance if needed. The manufacturer's instructions for Lantus prefilled insulin pen dated June 2022, indicated to store unopened Lantus in the refrigerator between 36-46 degrees F and do not freeze. The licensee's Medication Refrigerator Checks policy dated July 17, 2018, indicated according to safe medication handling, temperatures of the refrigerator should remain between 35-46 degrees. Daily checks of the refrigerators containing medications would be checked and recorded. An audit of compliance with this policy would be completed on a monthly basis. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed 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	01890			

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01890	Continued From page 56 review, the licensee failed to ensure medications included the open date and expiration date for time sensitive medications for eight residents (R1, R3, R7, R8, R9, R10, R11, R12). In addition, the licensee failed to ensure medication containers had the original prescription labels in one of two medication carts. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 21, 2023, at 10:25 a.m., the surveyor observed the medication cart on Cardinal Court with unlicensed personnel (ULP)-I and confirmed the following: -R9's opened Asmanex twisthaler 220 micrograms (mcg) lacked an opened and expiration date; -R9's opened Spiriva Respimat inhaler lacked an opened and expiration date; -R10's opened latanoprost 0.005% eye drops lacked an opened and expiration date; and -one opened Breo Ellipta inhaler, one opened Spiriva handheld inhaler, one opened fluticasone nasal spray and erythromycin 0.5% eye ointment lacked prescription labels; ULP-I stated staff should be dating when opening eye drops, inhalers and insulins. On August 21, 2023, at 11:13 a.m., the surveyor observed the medication cart on Assisted Living	01890			

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01890	Continued From page 57 Plus unit with ULP-D and confirmed the following: -R3's opened alphagan eye drop lacked an opened and expiration date; -R11's opened latanoprost 0.005% eye drop lacked an opened and expiration date; -R11's opened cosopt 2% eye drop lacked an opened and expiration date; -R12's opened tobrex 0.3% eye drop lacked and opened and expiration date; and -seven pre-filled insulin syringes stored in a clear plastic cup in the locked box of the medication cart with morphine 0.2 milliliters (ml) lacked labels. ULP-D stated the prefilled morphine syringes were being prepared either by the hospice nurse or facility nurse. ULP-D stated everyone knew who the morphine syringes were for because they were being counted in the narcotic blood every shift and they only had one resident on liquid morphine on the unit. On August 21, 2023, at 2:20 p.m., the surveyor reviewed the medication room on Cardinal Court, with ULP-F. ULP-F observed and confirmed the following: -R1's opened Lantus Flexpen lacked the opened and expiration date; -R7's opened Lantus Flexpen lacked the opened and expiration date; and -R8's opened Lantus Flexpen lacked the opened and expiration date. ULP-F stated the opened Lantus Flexpen's are supposed have a label with the opened and expiration date on the Lantus Flexpen. On August 21, 2023, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated ULP are trained to include the open and expiration date on opened Lantus Flexpen.	01890			

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01890	Continued From page 58 The manufacturer's instructions for Asmanex Twisthaler dated June 2021, indicated to discard 45 days after opening the foil pouch. The manufacturer's instructions for Spiriva Respimat inhaler dated November 2021, indicated to discard three (3) months after first use. The manufacturer's instructions for latanoprost (Xalatan) eye drops dated August 2011, indicated to discard six (6) weeks after opened. The manufacturer's instructions for Breo Ellipta inhaler dated 2019, indicated to write the date the inhaler was opened and discard six (6) weeks after opened. The manufacturer's instructions for cosopt (Dorzolamide) eye drops dated January 2020, indicted to discard 28 days after opened. The manufacturer's instructions for Alphagan eye drops dated February 2022, indicated to discard 28 days after opened. The manufacturer's instructions for Tobrex eye drops dated March 27, 2023, indicated to discard 28 days after opened. The FDA (Federal Drug Administration) guidelines revised May 2019 indicated Lantus Flexpen's are not to be used after being opened for 28 days. The licensee's Central Storage of Medications policy dated August 5, 2021, indicated medication that are centrally stored would be kept in their original containers bearing the original prescription label with legible information stating the prescription number, name of the drug,	01890			

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01890	Continued From page 59 strength and quantity of the drug, expiration date of time-dated drug, directions for use, the client's name, the prescriber's name, the date of issue, and the name and address of the dispensing pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's	01910			

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01910	Continued From page 60 record the disposition of the medications as required for one of one resident (R5) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Discharged Resident/Client Roster dated August 21, 2023, indicated R5 was expired on May 30, 2023. R5's diagnoses included dementia. R5's discharge summary dated May 30, 2023, indicated R5 received medication management services. R5's May 2023 medication administration record indicated R5 received the following medications: -Duloxetine 20 mg (milligrams) daily; -Metoprolol 25 mg daily; -Risperidone 0.5 mg in the a.m.; -Risperidone 0.25 mg at HS (hours of sleep); -Stool softener with laxative one twice a day; -Dicyclonine 20 mg four times a day; -Omeprazole 20 mg daily; -Trazadone 100 mg daily; -Tylenol 325 mg, two tablets, daily at 6:00 p.m.; -Ofloxacin 0.3% ear drops daily; and -Cipro 500 mg twice a day, times seven (7) days.	01910			

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01910	Continued From page 61 R5's Medication Destruction Record dated June 29, 2023, listed the above medications and quantity of the medication. The Medication Destruction Record was only signed by office person (OP)-K. R5's Medication Destruction Record dated June 29, 2023, did not include the names of the staff involved in the disposition. On August 24, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated R5's Medication Destruction Record did not include the signature of the staff involved in the destruction of R5's medications. CNS-B stated she should have signed R5's Medication Administration Record. The Licensee's Disposal of Medication policy dated December 15, 2008, indicated upon disposition, the licensee must document in the resident medication destruction record the disposition of the medication including: the names of staff and other individuals involved in the disposition. Medication must be either returned to the pharmacy for destruction or destroyed by the RN (registered nurse) or a Pharmacist with one other staff member as a witness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950			

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01950	Continued From page 62 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse (RN) for one of one unlicensed personnel ((ULP)-G). In addition, the licensee failed to ensure instructions, specified in writing, for each resident and documented those instructions in the resident's record for one of one resident (R3) who received blood glucose monitoring. 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).	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2023
NAME OF PROVIDER OR SUPPLIER VILLA VISTA AND CARDINAL COURT		STREET ADDRESS, CITY, STATE, ZIP CODE 1220 VILLA COURT DRIVE CROMWELL, MN 55726			
(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
01950	Continued From page 63 The findings include: ULP-G ULP-G started employment on October 11, 2006, under the comprehensive home care license and began providing assisted living services on August 1, 2021 On August 22, 2023, at 7:05 a.m., the surveyor observed ULP-G scan R1's Lire Blood Glucose monitor, located on R1's left upper arm. ULP-G stated R1 showed her how to scan his Lire Blood Glucose Monitor. ULP-G's employee record lacked evidence to indicate ULP-G was trained and demonstrated competency to an RN to manage R1's Lire Blood glucose Monitor. On August 24, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated ULP-G's employee record lacked evidence ULP-G had been trained on R1's Lire Blood Glucose Monitor. WRITTEN INSTRUCTIONS R3 R3's diagnoses included diabetes type II and dementia. R3's prescriber orders dated July 18, 2023, included blood glucose (sugar) monitoring daily. R3's Medication/Treatment Plan/Therapy Management Plan dated January 6, 2015, indicated R3 required blood glucose monitoring services. R3's August 2023, medication administration record (MAR) indicated R3 received daily blood glucose monitoring.	01950			

Minnesota Department of Health

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01950	Continued From page 64 On August 22, 2023, at 7:18 a.m., the surveyor observed ULP-D check R3's blood glucose at the dining table with the use of a blood glucose meter. ULP-D stated there were no blood glucose parameters set in R3's MAR of when to notify the nurse and further stated ULP-D stated R3's blood glucose readings were stable. On August 23, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated they did not set blood glucose parameters for when to notify the nurse for blood glucose monitoring and verified R3's record did not include parameters for blood glucose No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01950			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three unlicensed personnel ((ULP)-D, ULP-F, ULP-G) who performed medication setup for later administration.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2023
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02310	Continued From page 65 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 21, 2023, at 11:13 a.m., the surveyor observed the medication cart on Assisted Living Plus unit with ULP-D. In the drawer of the medication cart were stacks of several medication cups containing pills. Each medication cup had initials and times written on the cups. ULP-D stated she sets up all of the resident's medications scheduled to be given for the entire day at the beginning of her shift, including medications to be given on the evening and night shift by another staff. ULP-D stated she usually works the day shift and was scheduled to work 7:00 a.m. to 3:00 p.m. or whenever staff relieves her. On August 21, 2023, at 11:36 a.m., the surveyor observed ULP-D take a stack of prefilled medication cups from the medication cart and walk around to the dining tables handing out the medication cups to the residents who had medications due at noon time one resident after the other. ULP-D did not document the administration of medications after administering the medications to the residents in the dining room. Medication Administration Record was not on the medication cart and rather located on the desk at the nurse's station.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/24/2023
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02310	Continued From page 66 On August 21, 2023, at 11:57 a.m., clinical nurse supervisor (CNS)-B stated staff were able to set up resident medications at the beginning of their shift for their entire shift because it gets busy during the day with resident cares. CNS-B stated staff should not be setting up medications for other staff to administer. CNS-B stated staff usually sign off medications administered at one time and not at the time of administration. On August 21, 2023, at 2:20 p.m., the surveyor observed the medication cart on the Cardinal Court unit with ULP-F. In the top drawer of the medication cart there were several medications cups containing oral medications. Each medication cup had initials on the cups. ULP-F stated he setup the resident's medications for 2:00 p.m., 4:00 p.m., 5:00 p.m., and HS (hours of sleep) at the beginning of his shift. ULP-F stated he worked 2:00 p.m. to 9:00 p.m. On August 22, 2023, at 7:00 a.m., the surveyor observed the medication cart on the Cardinal Court unit with ULP-G. In the top drawer of the medication cart there were several medications cups containing oral medications. Each medication cup had initials on the cups. ULP-G stated when she arrived this morning, ULP-G set up all the resident's oral medication, placing the medications in medication cups with the resident's initials and placing the medication cups in the top draw of the medication cart. ULP-G stated she does this because she is so busy in the morning and if she did not setup the medications the medication pass would take so long. At 7:05 a.m., the surveyor observed ULP-G take seven (7) initialed medications cups from the medication cart and stack the medications cups one on top of the other. ULP-G walked up to the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/24/2023
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02310	Continued From page 67 second floor in Cardinal Court and administer the medications to the seven (7) residents in their apartments. ULP-G did not document the administration of medications after administering the medications to the residents. ULP-G went back down stair. At 7:40 a.m. ULP-G pushed the medication cart to outside the Cardinal Court dining room. ULP-G removed initialed medication cups from the top drawer of the medication cart and administer the medications to the residents in the dining room. ULP-G did not document the administration of medications after administering the medications to the residents in the dining room. ULP-G stated she documents the administration of medications on the resident's MAR (medication administration record) after she has completed administering the resident's morning medications. The licensee's Administration of Medication policy reviewed August 5, 2021, indicated medications were to be set up for one resident at a time. Medications may be setup prior to each administration time on a tray with name identified, or may be setup and given to one resident at a time. Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08. Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff.	02310			

Minnesota Department of Health

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02310	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (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 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 two of two residents (R3, R7) were treated with dignity and respect when unlicensed personnel (ULP)-D,	02410		

Minnesota Department of Health

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02410	Continued From page 69 ULP-G provided treatment and medication management services to residents in a public setting. 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: R3 R3's prescriber orders dated July 18, 2023 included Alphagan 1% solution (decreases pressure in the eye) one drop in both eyes twice a day and blood glucose monitoring daily. R3's Medication/Treatment Plan/Therapy Management Plan dated January 6, 2015, indicated R3 required medication management and blood glucose monitoring services. On August 21, 2023, at 11:36 a.m., the surveyor observed ULP-D administer R3's eye drops and perform blood glucose monitoring with the use of a blood glucose meter for R3 during breakfast while R3 was sitting at the dining room table with several other residents in the dining room. ULP-D stated it was more convenient to administer resident medications and treatments in the dining room when all residents were together in one room rather than going to each of the resident rooms. R7 On August 22, 2023, at 7:40 a.m., the surveyor observed ULP-G to perform blood glucose monitor for R7, while R7 was sitting at the dining room table, with three (3) other residents for	02410			

Minnesota Department of Health

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02410	Continued From page 70 breakfast. ULP-G stated she was trained to perform treatments in a private location. On August 24, 2023, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to administer eye drops in a private setting and it was permissible to check a resident's blood glucose in the dining room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 08/21/23
Time: 10:30:00
Report: 8010231128

Food and Beverage Establishment Inspection Report

Page 1

Location:

Villa Vista And Cardinal Court
1220 Villa Court Drive
Cromwell, MN55726
Carlton County, 09

Establishment Info:

ID #: 0037580
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186443331
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING CYCLE-TURNED TEMP TAPE BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 167 Degrees Fahrenheit - Location: FRIED RICE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: TATOR TOT HOTDISH
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: MEATBALLS
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: PORKCHOPS
Violation Issued: No

Type: Full
Date: 08/21/23
Time: 10:30:00
Report: 8010231128
Villa Vista And Cardinal Court

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Walk-In Freezer

Temperature: Degrees Fahrenheit - Location: FOODS FROZEN

Violation Issued: No

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

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 8010231128 of 08/21/23.

Certified Food Protection Manager: Sherry M. Korpi

Certification Number: FM27880 Expires: 12/01/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sherry Korpi
Kitchen Manager

Signed: _____

8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010231128		Food Establishment Inspection Report																		
DEPARTMENT OF HEALTH Minnesota Department of Health Minnesota Department of Health PO Box 64975 St. Paul, MN 55164-0975		No. of RF/PHI Categories Out					0		Date 08/21/23											
		No. of Repeat RF/PHI Categories Out					0		Time In 10:30:00											
		Legal Authority MN Rules Chapter 4626							Time Out											
Villa Vista And Cardinal Court		Address 1220 Villa Court Drive			City/State Cromwell, MN			Zip Code 55726		Telephone 2186443331										
License/Permit # 0037580		Permit Holder			Purpose of Inspection Full			Est Type		Risk Category										
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS																				
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item																				
Mark "X" in appropriate box for COS and/or R																				
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation																				
Compliance Status					COS		R		Compliance Status					COS		R				
Supervision									Time/Temperature Control for Safety											
1	IN	OUT	PIC knowledgeable; duties & oversight						18	IN	OUT	N/A	N/O	Proper cooking time & temperature						
2	IN	OUT	N/A	Certified food protection manager, duties					19	IN	OUT	N/A	N/O	Proper reheating procedures for hot holding						
Employee Health									20					IN	OUT	N/A	N/O	Proper cooling time & temperature		
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting						21	IN	OUT	N/A	N/O	Proper hot holding temperatures						
4	IN	OUT	Proper use of reporting, restriction & exclusion						22	IN	OUT	N/A		Proper cold holding temperatures						
5	IN	OUT	Procedures for responding to vomiting & diarrheal events						23	IN	OUT	N/A	N/O	Proper date marking & disposition						
Good Hygienic Practices									24					IN	OUT	N/A	N/O	Time as a public health control: procedures & records		
6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use					Consumer Advisory											
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth					25					IN	OUT	N/A	Consumer advisory provided for raw/undercooked food			
Preventing Contamination by Hands									Highly Susceptible Populations											
8	IN	OUT	N/O	Hands clean & properly washed					26					IN	OUT	N/A	Pasteurized foods used; prohibited foods not offered			
9	IN	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed				Food and Color Additives and Toxic Substances											
10	IN	OUT	Adequate handwashing sinks supplied/accessible						27					IN	OUT	N/A	Food additives: approved & properly used			
Approved Source									28					IN	OUT	Toxic substances properly identified, stored, & used				
11	IN	OUT	Food obtained from approved source						Conformance with Approved Procedures											
12	IN	OUT	N/A	N/O	Food received at proper temperature				29					IN	OUT	N/A	Compliance with variance/specialized process/HACCP			
13	IN	OUT	Food in good condition, safe, & unadulterated						Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.											
14	IN	OUT	N/A	N/O	Required records available; shellstock tags, parasite destruction															
Protection from Contamination																				
15	IN	OUT	N/A	N/O	Food separated and protected															
16	IN	OUT	N/A	Food contact surfaces: cleaned & sanitized																
17	IN	OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food																	
GOOD RETAIL PRACTICES																				
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.																				
Mark "X" in box if numbered item is not in compliance																				
Mark "X" in appropriate box for COS and/or R																				
COS=corrected on-site during inspection																				
R= repeat violation																				
Safe Food and Water					COS		R		Proper Use of Utensils					COS		R				
30	IN	OUT	N/A	Pasteurized eggs used where required					43		In-use utensils: properly stored									
31		Water & ice obtained from an approved source							44		Utensils, equipment & linens: properly stored, dried, & handled									
32	IN	OUT	N/A	Variance obtained for specialized processing methods					45		Single-use/single service articles: properly stored & used									
Food Temperature Control									46		Gloves used properly									
33		Proper cooling methods used; adequate equipment for temperature control							Utensil Equipment and Vending											
34	IN	OUT	N/A	N/O	Plant food properly cooked for hot holding				47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used									
35	IN	OUT	N/A	N/O	Approved thawing methods used				48		Warewashing facilities: installed, maintained, & used; test strips									
36		Thermometers provided & accurate							49		Non-food contact surfaces clean									
Food Identification									Physical Facilities											
37		Food properly labeled; original container							50		Hot & cold water available; adequate pressure									
Prevention of Food Contamination									51		Plumbing installed; proper backflow devices									
38		Insects, rodents, & animals not present							52		Sewage & waste water properly disposed									
39		Contamination prevented during food prep, storage & display							53		Toilet facilities: properly constructed, supplied, & cleaned									
40		Personal cleanliness							54		Garbage & refuse properly disposed; facilities maintained									
41		Wiping cloths: properly used & stored							55		Physical facilities installed, maintained, & clean									
42		Washing fruits & vegetables							56		Adequate ventilation & lighting; designated areas used									
Food Recalls:									57		Compliance with MCIAA									
Person in Charge (Signature)									58		Compliance with licensing & plan review									
Inspector (Signature)																				