DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 14, 2022

Administrator
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL33426015

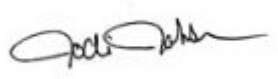
Dear Administrator:

On September 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility isin substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 27, 2022

Administrator
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379

RE: Project Number SL33426015

Dear Administrator:

On June 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 11, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the February 11, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 11, 2022, found not corrected at the time of the June 3, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0930-144g.50 Subd. 2 (d-e; 1-4) - Contract Information
0970-Waivers Of Liability Prohibited-144.50 Subd. 5 - $500.00
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1460-Orientation Of Staff And Supervisors-144g.63 Subdivision 1
1470-Content Of Required Orientation-144g.63 Subd. 2 - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E) - $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1830-Renewal Of Prescriptions-144g.71 Subd. 14
1880-Storage Of Medications-144g.71 Subd. 19 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
1910-Disposition Of Medications-144g.71 Subd. 22
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00
2310-Appropriate Care And Services-144g.91 Subd. 4 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on June 3, 2022 (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.

Also, at the time of this follow-up evaluation completed on June 3, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $3,000.00
0910-144g.50 Subd. 2 (a-b) - Contract Information
0920-144g.50 Subd. 2 (c) - Contract Information
0940-144g.50 Subd. 2 (e; 5-7) - Contract Information
1290-Background Studies Required-144g.60 Subdivision 1 - $3000.00
1610-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (a-B)

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $12,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal. **OR** Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

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 have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via

email to the following:

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

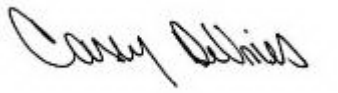
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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 Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	R 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL33426015-1 On June 01, 2022, through June 03, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 11, 2022. At the time of the survey, there were 20 residents: all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on June 02, 2022, issued for SL33426015-1, tag identification 2310. On June 03, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope of widespread and level three (I).	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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{0 000}	Continued From page 1 An immediate correction order was identified on June 03, 2022, issued for SL33426015-1, tag identification 1290. On June 03, 2022, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope of widespread and level three (I).	{0 000}		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced	0 340		

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0 340	Continued From page 2 by: Based on interview and record review, the licensee failed to have sufficient documentation of actions taken to comply with the correction orders for a survey completed on February 11, 2022. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 11, 2022, the Minnesota Department of Health completed a survey resulting in 43 correction orders issued. On March 11, 2022, the licensee's management company received their correction orders with the longest time period for correction of 21 days; however, the licensee did not receive the correction orders until March 31, 2022, at 2:23 p.m., when the licensee ended their contract with the management company. By April 21, 2022, the licensee would have needed to correct orders with a time period for correction of 21 days. On June 3, 2022, at approximately 1:40 p.m., licensed practical nurse (LPN)-A acknowledged 26 corrections had not been made pursuant the survey completed on February 11, 2022. No further information was provided.	0 340		

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{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level, potentially affecting the licensee's 20 current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a	{0 470}		

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{0 470}	Continued From page 4 violation that did not harm a licensee'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: The licensee held an assisted living facility license with a bed capacity of 27 residents; current census was 20 residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. On June 1, 2022, at approximately 11:17 a.m., licensed practical nurse (LPN)-A and nurse consultant (NC)-N indicated the licensee had not yet developed a staffing plan. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule, undated, indicated the licensee's clinical nurse supervisor or designee, would develop, write, and implement a staffing plan that would be evaluated for the	{0 470}		

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{0 470}	Continued From page 5 appropriateness of staffing levels in the facility and revised as needed, at a minimum of two times per year. No further information was provided.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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	{0 660}		

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{0 660}	Continued From page 6 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed health history and symptom screening and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of four employees (registered nurse (RN)-H, unlicensed personnel (ULP)-M) with records reviewed. In addition, the licensee failed to ensure employees completed TB training for four of four employees (RN-H, ULP-M, ULP-O, cook (C)-L) with records reviewed. This had the potential to affect all 20 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	{0 660}		

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{0 660}	Continued From page 7 a large portion or all of the residents). The findings include: The licensee's Facility Tuberculosis (TB) Risk Assessment dated May 3, 2022, indicated a low risk level. RN-H RN-H started employment on January 12, 2022. RN-H's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-M ULP-M started employment on April 15, 2022. ULP-M's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-O ULP-O started employment on March 15, 2022. ULP-O's employee record lacked evidence of TB training at time of hire, as required. C-L C-L started employment on April 25, 2022. C-L's employee record lacked evidence of TB training at time of hire, as required. The licensee's TB Prevention and Control policy, undated, indicated at time of hire and prior to any	{0 660}		

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{0 660}	Continued From page 8 contact with residents, all assisted living employees and all volunteers would be screened for TB, including review of TB symptoms with each new employee and volunteer, and completion of a two-step skin test or single interferon gamma release assay (IGRA) for tuberculosis. In addition, employees TB screening results would be kept in each employee medical file. Further, the policy indicated staff would be educated regarding TB at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided.	{0 660}		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider	0 910		

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0 910	Continued From page 9 when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R17) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R17's record lacked an assisted living contract to include the license number of the facility. R17 was admitted for assisted living services on April 4, 2022, with diagnoses including acute respiratory failure with hypoxia (oxygen deficiency). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. On June 1, 2022, at approximately at 4:09 p.m., licensed practical nurse (LPN)-A verified R17's	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	R 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
0 910	Continued From page 10 contract, Housing With Services Contract & Lease Agreement, dated April 4, 2022, was the contract currently being given to new residents, and verified the contract did not include the license number of the facility. LPN-A stated the contract was used prior to the licensee using a management company, and now that the management company was no longer involved with the licensee, the contract was being used again. The licensee's undated Section 2-Assisted Living Contracts policy, indicated the contract must include in a conspicuous place and manner, the legal name and the license number of the facility. No further information was provided.	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the	0 920		

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
0 920	Continued From page 11 resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of two residents (R17) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R17 was admitted for assisted living services on April 4, 2022, with diagnoses including acute respiratory failure with hypoxia (oxygen deficiency). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's contract, Housing With Services Contract & Lease Agreement, dated April 4, 2022, lacked the following content: -a disclosure of the category of assisted living	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
0 920	Continued From page 12 facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and -disclosure of the facility's ability to provide specialized diets. On June 1, 2022, at approximately at 4:09 p.m., licensed practical nurse (LPN)-A verified R17's contract was the contract currently being given to new residents and verified the contract did not include the above content and included content referring to the licensee as a "comprehensive home care agency," instead of an assisted living facility. LPN-A stated this contract was used prior to the licensee using a management company, and now that the management company was no longer involved with the licensee, this contract was being used again. The licensee's undated Section 2-Assisted Living Contracts policy, indicated the contract must include the category of assisted living facility license held, and if the facility is not an assisted living with dementia care, a disclosure that it does not hold an assisted living with dementia care license. In addition, the contract must include disclosure of the facility's ability to provide specialized diets. No further information was provided.	0 920		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility	{0 930}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 930}	Continued From page 13 who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R17) with records reviewed. This had the potential to affect all 20 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 the potential to affect a large portion or all the residents). The findings include: R17 was admitted for assisted living services on April 4, 2022, with diagnoses including acute	{0 930}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 930}	Continued From page 14 respiratory failure with hypoxia (oxygen deficiency). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's contract, Housing With Services Contract & Lease Agreement, dated April 4, 2022, lacked the following content: -contact information of the person representing the facility who is designated to handle and resolve complaints; -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On June 1, 2022, at approximately at 4:09 p.m., licensed practical nurse (LPN)-A verified R17's contract was the contract currently being given to new residents and verified the contract did not include the above content. LPN-A stated this contract was used prior to the licensee using a management company, and now that the management company was no longer involved with the licensee, this contract was being used again. The licensee's undated Section 2-Assisted Living Contracts policy, indicated the contract must include the following: -a description of the facility's complaint resolution	{0 930}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
{0 930}	Continued From page 15 process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the rights under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding the transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; and -contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. No further information was provided.	{0 930}		
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	0 940		

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0 940	Continued From page 16 housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R17) with records reviewed. This had the potential to affect all 20 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 the potential to affect a large portion or all the residents). The findings include: R17 was admitted for assisted living services on April 4, 2022, with diagnoses including acute respiratory failure with hypoxia (oxygen	0 940		

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0 940	Continued From page 17 deficiency). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's contract, Housing With Services Contract & Lease Agreement, dated April 4, 2022, lacked the following content: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a 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; and -the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On June 1, 2022, at approximately at 4:09 p.m., licensed practical nurse (LPN)-A verified R17's contract was the contract currently being given to new residents and verified the contract did not include the above content. LPN-A stated this contract was used prior to the licensee using a management company, and now that the management company was no longer involved with the licensee, this contract was being used	0 940		

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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0 940	Continued From page 18 again. The licensee's undated Section 2-Assisted Living Contracts policy, indicated the contract must include the following: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a 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; and -the toll-free phone number for the Minnesota Adult Abuse Reporting Center. No further information was provided.	0 940		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	{0 970}		

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{0 970}	Continued From page 19 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 20 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Housing With Services Contract & Lease Agreement included a clause on page 8, section 19, that indicated the resident agreed "that Landlord is not responsible for any loss or damage to your personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Landlord's control." The agreement also included a clause on page 10, section 23, that the resident assumed the risk for their own safety and for the safety of guests and agents, and would hold harmless the Landlord, it's employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property arising from or out of the use of the rented premises or any part of the Landlord's property. Further, the agreement included a clause on page 10, section 25, that indicated the Landlord was not liable to the resident or their guests for any injury, death or property damage occurring in the apartment or on Landlord's premises and would hold harmless the Landlord from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment	{0 970}		

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{0 970}	Continued From page 20 or on Landlord's property. On June 1, 2022, at approximately at 4:09 p.m., licensed practical nurse (LPN)-A verified the licensee's contract was the contract currently being given to new residents and verified the contract included the above content. LPN-A stated this contract was used prior to the licensee using a management company, and now that the management company was no longer involved with the licensee, this contract was being used again. The licensee's undated Section 2-Assisted Living Contracts policy, indicated the contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. No further information was provided.	{0 970}		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 21 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services for two of four employees (cook (C)-L and unlicensed personnel (ULP)-M) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: C-L C-L had a hire date of April 25, 2022. C-L's employee record included a Final Registry Results Form, dated April 22, 2022, from the Minnesota Department of Human Services (DHS); however, lacked evidence of a background clearance as required. On June 3, 2022, at approximately 9:30 a.m., administrative assistant (AA)-K verified C-L's record lacked a background study clearance. AA-K attempted to verify C-L's background	01290	On June 03, 2022, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope of widespread and level three (I).	

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01290	Continued From page 22 clearance on the DHS website but was not able to verify that it was complete. On June 3, 2022, at approximately 12:50 p.m., AA-K stated she was able to speak to a representative from DHS background study division and was told that C-L had not completed her fingerprinting, therefore, the background study was not complete. AA-K stated C-L was currently working in the kitchen at the time of the survey. On June 3, 2022, at approximately 1:03 p.m., the surveyor observed C-L washing dishes in the kitchen. C-L stated she went to complete her fingerprinting around May 1, 2022, and was told the equipment was not working and there would be a two-hour delay, or she could reschedule. C-L chose to reschedule and stated she went back to the licensee and informed AA-K that she needed to reschedule; however, stated she didn't know if she needed to reschedule or if the licensee needed to do that. C-L was never rescheduled. ULP-M ULP-M had a hire date of April 15, 2022, to work the overnight shift for the licensee, and usually worked alone. ULP-M's employee record included a Final Registry Results Form, dated May 13, 2022, from DHS; however, lacked evidence of a background clearance as required. On June 3, 2022, at approximately 9:35 a.m., AA-K verified ULP-M's record lacked a background study clearance. AA-K attempted to verify ULP-M's background clearance on the DHS website but was not able to verify that it was complete.	01290		

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01290	Continued From page 23 On June 3, 2022, at approximately 12:50 p.m., AA-K stated she was able to speak to a representative from DHS background study division and was told that ULP-M had not signed her "consent and disclosure," therefore, the background study was not complete. AA-K stated ULP-M was on the schedule to work overnights this weekend. On June 3, 2022, at approximately 12:55 p.m., AA-K stated she thought both employees had taken care of the background study procedure and would be scheduling them both as soon as possible to complete their background studies. The licensee's Background Checks policy, undated, indicated all employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne	{01370}		

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{01370}	Continued From page 24 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care, for two of two unlicensed personnel (ULP-O, ULP-M) to include all required content with records reviewed.	{01370}		

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{01370}	Continued From page 25 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-O ULP-O was hired on March 15, 2022, to provide direct care services to residents of the facility. ULP-O's employee record lacked documentation of training and competency evaluations for the following topics: -reports of changes in the resident's condition to the supervisor designated by the facility; -standby assistance techniques and how to perform them; and -medication, exercise, and treatment reminders. ULP-M ULP-M was hired on April 15, 2022, to provide direct care services to residents of the facility. ULP-M's employee record lacked documentation of training and competency evaluations for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -standby assistance techniques and how to perform them;	{01370}		

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{01370}	Continued From page 26 -medication, exercise, and treatment reminders; -preparation of modified diets as ordered by a licensed health professional; -awareness of commonly used health technology equipment and assistive devices. On June 3, 2022, at approximately 8:15 a.m., administrative assistant (AA)-K confirmed ULP-O and ULP-M's employee records lacked documentation of training and/or competency evaluations for the above topics, as required. The licensee's undated Assisted Living Orientation-ULP Staff policy, indicated ULPs who are not a registered nursing assistant would receive additional training with a written or oral competency test, and would receive additional training with a written or oral competency test and a skill demonstration, on the required topics. No further information was provided.	{01370}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	{01380}		

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{01380}	Continued From page 27 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care, for two of two unlicensed personnel (ULP-O, ULP-M) to include all required content with records reviewed. 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-O ULP-O was hired on March 15, 2022, to provide direct care services to residents of the facility. ULP-O's employee record lacked documentation of training and competency evaluations for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and	{01380}		

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{01380}	Continued From page 28 developmental needs of the resident; and -range of motioning and positioning. ULP-M ULP-M was hired on April 15, 2022, to provide direct care services to residents of the facility. ULP-M's employee record lacked documentation of training and competency evaluations for the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; and -range of motioning and positioning. On June 3, 2022, at approximately 8:15 a.m., administrative assistant (AA)-K confirmed ULP-O and ULP-M's employee records lacked documentation of training and/or competency evaluations for the above topics, as required. The licensee's undated Assisted Living Orientation-ULP Staff policy, indicated ULPs who are not a registered nursing assistant would receive additional training with a written or oral competency test, and would receive additional training with a written or oral competency test and a skill demonstration, on the required topics. No further information was provided.	{01380}		
{01440} SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	{01440}		

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{01440}	Continued From page 29 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two unlicensed personnel (ULP)-O, ULP-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01440}		

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{01440}	Continued From page 30 The findings include: ULP-O ULP-O was hired on March 15, 2022, to provide direct care services to residents of the facility. ULP-O's employee record lacked evidence an RN conducted direct supervision of ULP-O within 30 days of performing delegated tasks. ULP-M ULP-M was hired on April 15, 2022, to provide direct care services to residents of the facility. ULP-M's employee record lacked evidence an RN conducted direct supervision of ULP-M within 30 days of performing delegated tasks. On June 3, 2022, at approximately 9:30 a.m., administrative assistant (AA)-K verified ULP-O and ULP-M's records lacked evidence of supervision within 30 days of performing delegated tasks. The licensee's undated Supervision of Unlicensed Personnel policy, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the facility and has been trained and determined competent to perform all the tasks assigned. No further information was provided.	{01440}		
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors	{01460}		

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{01460}	Continued From page 31 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing and supervising direct services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of five employees (registered nurse (RN)-H) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 8, 2022, at approximately 3:08 p.m., licensed practical nurse (LPN)-A stated the licensee employed RN-H to cover on-call from 6:00 p.m., to 6:00 a.m., and she would come to the facility if needed because she lived in the area. RN-H had a hire date of January 12, 2022.	{01460}		

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{01460}	Continued From page 32 RN-H's record lacked evidence of completing orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On June 3, 2022, at approximately 9:30 a.m., administrative assistant (AA)-K confirmed RN-H did not receive the orientation to assisted living facility licensing requirements and regulations. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided.	{01460}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	{01470}		

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{01470}	Continued From page 33 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (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.	{01470}		

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{01470}	Continued From page 34 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for four of four employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-O, ULP-M, cook (C)-L) with records reviewed. 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: LPN-A, ULP-O, ULP-M and C-L's records lacked evidence to indicate the employees received orientation to include the required topics. LPN-A LPN-A started employment on October 19, 2021. LPN-A's record lacked the following required content: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	{01470}		

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{01470}	Continued From page 35 Center (MAARC); -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. ULP-O ULP-O had a start date of March 15, 2022. ULP-O's record lacked the following required content: -an overview of this chapter; -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 principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -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; -handling of residents' complaints, reporting of complaints, and where to report complaints,	{01470}		

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{01470}	Continued From page 36	{01470}		

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.

ULP-M
ULP-M had a start date of April 15, 2022.
ULP-M's record lacked the following required content:
-an overview of this chapter;
-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 principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
-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;
-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

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{01470}	Continued From page 37 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. C-L C-L had a hire date of April 25, 2022. C-L's record lacked the following required content: -an overview of this chapter; -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 principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -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; -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.	{01470}		

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{01470}	Continued From page 38 On June 3, 2022, at approximately 9:45 a.m., administrative assistant (AA)-K confirmed the above missing content and stated the licensee used an educational software program to cover the content and employees were assigned courses to complete upon hire; however, the courses had not been updated when the licensee began providing services under the assisted living licensure. The licensee's Assisted Living Orientation - ULP Staff policy, undated, indicated newly hired unlicensed personnel would receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided.	{01470}		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01610		

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01610	Continued From page 39 planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for two of three residents (R16, R17) as required. 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: R16 was admitted for assisted living services on March 9, 2022. R16's diagnoses included congestive heart failure, cardiac pacemaker, muscle weakness and type 2 diabetes. R16's Service Plan, effective May 17, 2022, indicated R16 received services including ambulation/exercise program, bathing assistance, dressing, mobility assistance, grooming, glucose monitoring, medication administration, laundry and housekeeping. R16's Housing With Services Contract & Lease Agreement was signed March 9, 2022.	01610		

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01610	Continued From page 40 R16's record included an Assessment As Of Date intended as the pre-admission assessment, was dated March 9, 2022. R16's Assessment As Of Date, intended as the admission assessment, indicated the assessment was completed in person by the RN on March 10, 2022, not prior to the date on which the prospective resident executed a contract with the facility or the date on which the prospective resident moved in, whichever was earlier, as required. R17 was admitted for assisted living services April 4, 2022. R17's diagnoses included acute respiratory failure with hypoxia (oxygen deficiency), compression of brain, morbid obesity, cerebral edema (swelling in the brain). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's Housing With Services Contract & Lease Agreement was signed April 4, 2022. R17's record included an Assessment As Of Date intended as the admission assessment, which indicated the assessment was completed in person by the RN on April 7, 2022, not prior to the date on which the prospective resident executed a contract with the facility or the date on which the prospective resident moved in, whichever was earlier, as required. On June 1, 2022, at approximately 1:43 p.m., nurse consultant (NC)-N confirmed R16 and	01610		

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01610	Continued From page 41 R17's initial assessments should have been completed prior to the date on which the contract was executed, or on the date the residents moved into the facility, whichever was earlier, and verified R16 and R17's initial assessment were not completed timely. The licensee's Initial and On-going Nursing Assessment of Residents policy, undated, indicated the RN would complete the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required, including a pre-admission assessment, a 14-day assessment completed up to 14-days after start of services, and an ongoing assessment completed periodically but no less than every 90-days, or when there was a change in the resident's condition. No further information was provided.	01610		
{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	{01620}		

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{01620}	Continued From page 42	{01620}		

the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for three of three residents (R16, R17, R18) with records reviewed.

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:

R16 was admitted for assisted living services on March 9, 2022.

R16's diagnoses included congestive heart failure, cardiac pacemaker, muscle weakness and type 2 diabetes.

R16's Service Plan, effective May 17, 2022, indicated R16 received services including

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{01620}	Continued From page 43 ambulation/exercise program, bathing assistance, dressing, mobility assistance, grooming, glucose monitoring, medication administration, laundry and housekeeping. R16's Housing With Services Contract & Lease Agreement was signed March 9, 2022. R16's record included an Assessment As Of Date, intended as the 14-day assessment, which indicated the assessment was completed in person by the RN on March 25, 2022 (16 days after the initiation of services), not within 14 calendar days after the initiation of services, as required. R17 was admitted for assisted living services April 4, 2022. R17's diagnoses included acute respiratory failure with hypoxia (oxygen deficiency), compression of brain, morbid obesity and cerebral edema (swelling in the brain). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's Housing With Services Contract & Lease Agreement was signed April 4, 2022. R17's record included an Assessment As Of Date, intended as the 14-day assessment, which indicated the assessment was completed in person by the RN on May 12, 2022 (35 days after the initiation of services), not within 14 calendar days after the initiation of services, as required.	{01620}		

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{01620}	Continued From page 44 R18 was admitted for assisted living services on March 2, 2022. R18's diagnoses included Parkinson's Disease, congestive heart failure, persistent atrial fibrillation (irregular and faster heartbeat) and anxiety. R18's Service Plan, effective May 17, 2022, indicated R18 received services including bathing assistance, behavior management, dressing, medication administration and reminders, laundry and housekeeping. R18's Cornerstone Management Services (previous management company) Assisted Living Agreement was executed on March 1, 2022, and was signed March 4, 2022. R18's record included an Assessment As Of Date, intended as the admission assessment, which indicated was completed in person by the RN on March 2, 2022, and an Assessment As of Date, intended as the 14-day assessment, which indicated the assessment was completed in person by the RN on March 22, 2022 (20 days after the initiation of services), not within 14 calendar days after the initiation of services, as required. On June 1, 2022, at approximately 1:43 p.m., nurse consultant (NC)-N confirmed R16, R17, and R18's 14-day assessments should have been completed within 14 calendar days after the initiation of services, and verified R16, R17, and R18's 14-day assessments were not completed timely. The licensee's Initial and On-going Nursing Assessment of Residents policy, undated,	{01620}		

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{01620}	Continued From page 45 indicated the RN would complete the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required, including a pre-admission assessment, a 14-day assessment completed up to 14-days after start of services, and an ongoing assessment completed periodically but no less than every 90-days, or when there was a change in the resident's condition. No further information was provided.	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	{01640}		

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{01640}	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included a signature documenting agreement on the services for one of three residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's records lacked evidence the licensee had developed a current service plan that included a signature documenting agreement on the services provided. R4 R4 was admitted on March 2, 2018. R4's diagnoses included diabetes, hypothyroidism (underactive thyroid), chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure), arthritis, depression and anxiety. R4's Wildwood Assisted Living Agreement was signed July 29, 2021. R4's Service Plan, effective May 17, 2022, indicated R4 received services to include	{01640}		

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{01640}	Continued From page 47 medication administration, activity assistance, bathing assistance, behavior management, dressing, oxygen administration, vitals monitoring, nail care, skin care, laundry and housekeeping. R4's Service Plan was signed by licensed practical nurse (LPN)-A on May 17, 2022; however, lacked R4's signature, documenting agreement on the services provided. On June 3, 2022, at approximately 10:15 a.m., administrative assistant (AA)-K verified R4 had never signed a Service Plan. The licensee's Assisted Living Contracts-Attachment D Service Plan policy, undated, indicated the initial service plan and each revision must be signed by both the resident and an authorized representative of the provider. No further information was provided.	{01640}		
{01700} SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	{01700}		

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{01700}	Continued From page 48	{01700}		

medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure medication management assessments completed by the registered nurse (RN) to determine what medication management services would be provided included all required content for four of four residents (R1, R16, R17, R18) with records reviewed.

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

The findings include:

During the entrance conference on June 1, 2022, at approximately 9:08 a.m., licensed practical nurse (LPN)-A confirmed the licensee provided

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{01700}	Continued From page 49 medication management services to residents. R1, R16, R17, and R18's records lacked evidence the RN conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking. R1 R1's diagnoses included epilepsy, depression, fibromyalgia (chronic muscle pain, tenderness, fatigue, sleep disturbance), generalized anxiety and borderline personality disorder. R1's Service Plan, dated May 17, 2022, indicated R1 received services which included activity assistance, ambulation/exercise program, bathing assistance, behavior management, medication administration, vital monitoring, laundry and housekeeping. R1's Scheduled Medications, undated, listed on the electronic medical record, included one mild pain reliever, an antianxiety, medication used to decrease edema, one moderate pain reliever, one antihypertensive, two antidepressants, an allergy medication and a nutritional supplement. R1's record lacked evidence the RN conducted an assessment to include identification and review of all medications the resident was known to be taking. R16 R16's diagnoses included congestive heart failure, cardiac pacemaker, muscle weakness and type 2 diabetes. R16's Service Plan, effective May 17, 2022, indicated R16 received services including	{01700}		

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{01700}	Continued From page 50 ambulation/exercise program, bathing assistance, dressing, mobility assistance, grooming, glucose monitoring, medication administration, laundry and housekeeping. R16's Scheduled Medications, undated, listed on the electronic medical record, included one mild pain reliever, an antihypertensive, an antidepressant, two insulins, one supplement and one medication to treat atrial fibrillation (fast irregular heartbeat). R16's record lacked evidence the RN conducted an assessment to include identification and review of all medications the resident was known to be taking. R17 R17's diagnoses included acute respiratory failure with hypoxia (oxygen deficiency), compression of brain, morbid obesity and cerebral edema (swelling in the brain). R17's Service Plan, effective May 17, 2022, indicated R17 received services including medication administration, dressing, grooming, assistance with bathing, toileting reminder, housekeeping and laundry. R17's Scheduled Medications, undated, listed on the electronic medical record, included three antihypertensives, one nutritional supplement, one mouth rinse and one medication to treat loose stools. R17's record lacked evidence the RN conducted an assessment to include identification and review of all medications the resident was known to be taking.	{01700}		

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{01700}	Continued From page 51	{01700}		

R18
R18's diagnoses included Parkinson's Disease, congestive heart failure, persistent atrial fibrillation (irregular and faster heartbeat) and anxiety.

R18's Service Plan, effective May 17, 2022, indicated R18 received services including bathing assistance, behavior management, dressing, medication administration and reminders, laundry and housekeeping.

R18's Scheduled Medications, undated, listed on the electronic medical record, included one inhaler to prevent wheezing and shortness of breath, one antidepressant, one medication to treat edema, one medication to treat high cholesterol, one medication to treat Parkinson's Disease, one antihypertensive, one blood thinner, one medication to treat heart failure and one antacid.

R18's record lacked evidence the RN conducted an assessment to include identification and review of all medications the resident was known to be taking.

On June 1, 2022, at approximately 3:08 p.m., licensed practical nurse (LPN)-A verified R1, R16, R17, and R18's records lacked evidence that the medication assessment included the identification and review of all of the medications each resident was known to be taking.

The licensee's undated Initial and On-Going Nursing Assessment of Residents policy, indicated the RN would complete a comprehensive assessment of the individual resident that would include a medication review including over-the-counter medications,

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
{01700}	Continued From page 52 prescription medications and supplements to include the reason taken, the side effects, contraindications, allergic or adverse reactions, actions to address those, dosage, frequency of use, route administered, resident difficulties taking medications, resident's preferences, and interventions to manage the resident's medications and prevent medication diversion. The policy did not address the identification and review of all medications. No further information was provided.	{01700}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed and administered according to manufacturer's instructions for one of two residents (R6) with records reviewed.	{01760}		

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{01760}	Continued From page 53 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: R6's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure), osteoarthritis, depression and anxiety. R6's Service Plan, dated May 17, 2022, indicated R6 received services which included bathing assistance, behavior management, dressing, grooming, oxygen maintenance and medication administration. R6's June 2022 Med (medication) Admin (administration) Summary, indicated R6 received Symbicort 160-4.5 mcg (micrograms), inhale two puffs by mouth twice daily. On June 2, 2022, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-J conduct a medication pass for R6 which included administration of oral medications and the Symbicort inhaler. ULP-J handed the medication cup to R6 which she brought to her mouth, and then took a swallow of liquid from a drinking cup. ULP-J handed the Symbicort inhaler to R6, which she brought to her mouth and took two slow inhalations. R6 handed the inhaler back to ULP-J.	{01760}		

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{01760}	Continued From page 54	{01760}		

ULP-J did not instruct the resident to rinse her mouth out after the administration of the inhaler. ULP-J asked R6 if she needed anything, and then left the room.

On June 2, 2022, at approximately 8:50 a.m., ULP-J confirmed she had not instructed R6 to rinse her mouth out following administration of the Symbicort inhaler and stated she had never done that before and was unaware it was necessary; however, did verify the manufacturer's instructions directed to rinse mouth out after using the inhaler and to spit the water out.

On June 2, 2022, at approximately 9:11 a.m., licensed practical nurse (LPN)-A confirmed the manufacturer's instructions for inhaler administration should be followed, and ULP-J should have reminded R6 to rinse her mouth out after administration of her inhaler. LPN-A stated registered nurse (RN)-H had completed education for staff administering medications, on April 24, 2022, which included instructing residents to rinse their mouth following inhalation of inhalers and to spit the water out. LPN-A provided a document that confirmed ULP-J attended the education on that day.

On June 2, 2022, at approximately 9:23 a.m., LPN-A contacted RN-H by telephone and confirmed she discussed administration of inhalers during the training she held on April 24, 2022, and stated ULPs were directed to ensure residents rinsed their mouth after inhalations to prevent yeast infections.

The manufacturer's instructions for use of the Symbicort inhaler, last updated November 2020, directed to rinse mouth with water after breathing in the medications, to spit out the water and not to

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{01760}	Continued From page 55 swallow the water. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy, undated, included the RN may delegate to unlicensed personnel the task of administration of medications if the unlicensed personnel have satisfied the training requirements and has demonstrated the ability to competently follow the procedures. The policy did not specifically address administration of inhalers. No further information was provided.	{01760}		
{01830} SS=E	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for two of four residents (R14, R19) with records reviewed. 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).	{01830}		

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{01830}	Continued From page 56 The findings include: R14 R14's diagnoses included multiple sclerosis, depression, cognitive dysfunction and muscle spasms. R14's Service Plan, dated May 17, 2022, indicated R14 received assistance with bathing, catheter care, dressing, grooming, laundry and housekeeping and medication administration. R14's Assessment As Of Date dated March 23, 2022, indicated R14 received medication administration due to being unable to open his medications and directed staff would administer all medications. R14's most recent prescriber orders, dated January 23, 2021, 130 days past the annual renewal requirement, included the following medications: -amoxicillin (antibiotic) 500 mg (milligrams) one capsule three times daily by mouth; -Aquaphor (treats skin irritation) to buttocks twice daily topically; -baclofen (treats muscle spasms) 20 mg three times daily by mouth; -fish oil (dietary supplement) 1500 mg two capsules in the morning by mouth; -gabapentin (treats nerve pain) 300 mg two tablets twice daily by mouth; -gas relief 80 mg one tablet two times daily by mouth; -gent blad (antibiotic bladder irrigation to prevent urinary tract infection) 0.4 mg/ml (milliliter) irrigate bladder with 100 ml daily through urinary catheter; -melatonin (sleep aid) 5 mg one tablet at bedtime	{01830}		

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{01830}	Continued From page 57	{01830}		

by mouth;
-modafinil (reduces extreme sleepiness) 200 mg once daily in the morning by mouth;
-multi vitamin gummies (supplement) two gummies once daily by mouth;
-omeprazole (decreases stomach acid)20 mg one capsule daily by mouth;
-oxybutynin (treat overactive bladder) 5 mg one tablet three times daily by mouth;
-polyethylene glycol (treats constipation) mix one capful in liquid every two days by mouth;
-Senna S (treats constipation) 50-8.6 mg take two tablets two times daily by mouth;
-sertraline (treats depression) 100 mg one and one-half tablets daily by mouth;
-trazodone (treats depression) 100 mg one tablet daily by mouth; and
-vitamin D (supplement) 2000 units one capsule daily by mouth.

R19
R19's diagnoses included weakness, lumbar spinal stenosis (narrowing of spinal column compressing spinal cord), rheumatoid arthritis (chronic inflammatory disease affecting the joints), diabetes and anxiety.

R19's Service Plan, dated May 17, 2022, indicated R19 received assistance with bathing, behavior management, laundry, housekeeping, blood glucose monitoring and medication administration.

R19's Assessment As Of Date dated March 16, 2022, indicated R19 received full medication management and setup.

R19's most recent prescriber orders, dated October 20, 2020, 590 days past the annual renewal requirement, included the following

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{01830}	Continued From page 58 medications: -amitriptyline (treat mental/mood problems) 50 mg one tablet daily at bedtime by mouth; -atorvastatin (lower bad cholesterol) 20 mg one tablet once daily at bedtime by mouth; -Basaglar Kwikpen (long acting insulin) 100 units/3 ml give 65 units once daily subcutaneously (sq)(under the skin); -Capsaicin (topical pain reliever) 0.025% cream apply topically four times daily; -duloxetine dr (treat depression/anxiety) 60 mg one capsule daily by mouth; -gabapentin 600 mg two tablets daily by mouth; -hydroxychloroquine (treat rheumatoid arthritis) 200 mg one tablet daily by mouth; -levothyroxine (treat underactive thyroid) 125 mcg (micrograms) one tablet daily by mouth; -magnesium (supplement) 250 mg twice daily by mouth; -Mapap Arthritis Pain 650 mg two tablets four times daily by mouth; -metformin (control high blood sugar) 500 mg two tablets daily by mouth; -Multivit Tab-A-Vite (supplement) one tablet daily by mouth; -Novolog FlexPen (short acting insulin) give per sliding scale three times daily before meals sq; -polyethylene glycol mix one capful in liquid daily by mouth; and -Thera Tears liquid gel (eye lubricant) one drop both eyes four times daily. On June 1, 2022, at approximately 3:08 p.m., licensed practical nurse (LPN)-A confirmed R14 and R19's prescriber orders had not been updated at least annually as required. No further information was provided.	{01830}		

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{01880}	Continued From page 59	{01880}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and/or document medication refrigerator temperatures for two of two medication refrigerators (A, B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference of the follow-up survey on June 1, 2022, at approximately 9:08 a.m., licensed practical nurse (LPN)-A confirmed the licensee provided medication management services to the licensee's residents, including storage of medications. The surveyor requested a history of recorded temperature logs for medication refrigerators on the first and second floors. At 3:15 p.m., administrative assistant (AA)-K provided a form titled Fridge Temperature Log Upstairs; however, stated the log was from	{01880}		

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{01880}	Continued From page 60 the "downstairs [first floor-A] refrigerator" and stated she could not locate a temperature log for the "upstairs [second floor-B] refrigerator." FIRST FLOOR MEDICATION REFRIGERATOR A Review of the temperature logs provided for medication refrigerator A revealed documentation of 11 temperatures for the month of April 2022, with temperatures ranging from 32 to 34 degrees F (Fahrenheit), and although the temperatures were lower than the noted appropriate temperature range (36-46 degrees for medications) on the log, staff noted, "A" in the action code column, indicating no action was taken. In May 2022 staff recorded 7 temperatures on the log, ranging from 32.9 to 39 degrees F, and although four of the recorded temperatures were lower than the noted appropriate temperature range on the log, staff noted, "A" in the action code column, indicating no action was taken. The log lacked any documentation of temperatures for June 2022. On June 2, 2022, at approximately 9:57 a.m., LPN-A verified the temperature logs for medication refrigerator A were not being recorded daily and stated they attempted to have the night staff responsible for recording the temperatures; however, it was not being done consistently. During the surveyor's observation of the medication refrigerator A with LPN-A, the temperature was noted to be 36 degrees F. On June 3, 2022, at approximately 1:00 p.m., LPN-A verified medication refrigerator A was currently 35 degrees F and contained the following contents: -five unopened Victoza pens (antidiabetic	{01880}		

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{01880}	Continued From page 61 medication in a multiple dose pen shaped injector device used for insulin administration). SECOND FLOOR MEDICATION REFRIGERATOR B On June 2, 2022, at approximately 10:10 a.m., LPN-A verified the temperature logs for medication refrigerator B could not be located and stated the night staff were responsible for recording temperatures daily; however, she wasn't sure if this was being done because there were no logs found. During the surveyor's observation of the medication refrigerator B with LPN-A, the temperature was noted to be 40 degrees F. On June 3, 2022, at approximately 1:10 p.m., LPN-A verified medication refrigerator B was currently 37 degrees F and contained the following contents: -41 Gent Blad (sterile water with gentamicin (antibiotic) used to irrigate a urinary catheter) 0.4 milligram (mg) per milliliter (ml) prefilled syringes; -54 unopened Lantus insulin pens (long-acting insulin in a multiple dose pen shaped injector device used for insulin administration); -22 unopened Novolog FlexPens (short acting insulin in a multiple dose pen shaped injector device used for insulin administration); -one unopened Victoza pen; and -three unopened Humulin Kwikpen (intermediate acting insulin in a multiple dose pen shaped injector device used for insulin administration. The manufacturer's instructions for Victoza dated February 2021, indicated store unused Victoza pen in the refrigerator at 36-46 degrees F. Do not allow Victoza to freeze and do not use if it has been frozen.	{01880}		

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{01880}	Continued From page 62 The manufacturer's instructions for Lantus insulin pens revised December 2020, indicated storing unused pens in cool storage (36-46 degrees F) until first use. Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog FlexPen revised March 2021, indicated unopened pens should be stored in the refrigerator 36-46 degrees F. Do not allow the Novolog to freeze and do not use if it has been frozen. The manufacturer's instructions for Humulin KwikPen revised November 2019, indicated unused pens should be stored in the refrigerator at 36 to 46 degrees F. Do not freeze and do not use if it has been frozen. The licensee's Storage of Medications policy, undated, indicated the registered nurse would conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications, and included medications would be handled and stored per acceptable standards. No further information was provided.	{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.	{01890}		

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{01890}	Continued From page 63 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time-sensitive medications with an opened-on date for two of five residents (R7, R5). In addition, the licensee failed to ensure medication containers had the original prescription label for two of six residents (R16, R4) with records reviewed. 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). Findings include: On June 2, 2022, at approximately 9:57 a.m., the surveyor conducted an observation of the first and second floor medication carts with licensed practical nurse (LPN)-A. The first floor medication cart contained the following: -R7's calcitonin salmon nasal spray was dispensed from the pharmacy on March 7, 2022, and lacked the date the nasal spray was opened and would expire. The second floor medication cart contained the following: -R5's Lantus Solostar insulin pen was dispensed from the pharmacy on April 4, 2022, and lacked the date the insulin was opened and would expire; -R16's Lantus Solostar insulin pen and two	{01890}		

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{01890}	Continued From page 64 Novolog FlexPen insulin pens lacked a prescription label, the date the insulin pen was opened, and when the insulin pen would expire; and -R4's Novolog FlexPen insulin pen lacked a prescription label, the date the insulin pen was opened and when the insulin pen would expire. On June 2, 2022, at approximately 10:15 a.m., LPN-A confirmed all medications should have prescription labels, and medications with an accelerated expiration date should be labeled with the opened date and date of expiration. The manufacturer's instructions for calcitonin salmon nasal spray revised September 2017, directed to store open bottles at room temperature for 35 days or after having used 30 doses. The manufacturer's instructions for Lantus Solostar pens revised December 2020, directed once the pen is taken out of cool storage for use, it can be used for up to 28 days. Do not use after this time. The manufacturer's instructions for Novolog Flex pen revised March 2021, directed to discard the pen 28 days after opened. The licensee's Storage of Medications policy, undated, indicated the registered nurse would establish a system that addresses the storage and handling of medications; however, did not address labeling medications and dating time-sensitive medications with the opened date. No further information was provided.	{01890}		

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{01910}	Continued From page 65	{01910}		
{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 record the disposition of the medications as required for one of one resident (R20) upon discharge, with records reviewed. 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	{01910}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
{01910}	Continued From page 66 situation has occurred only occasionally). The findings include: R20 was discharged to her home on May 11, 2022, after receiving services for diagnoses including left hip fracture. R20's Discharge-Transfer Summary, printed June 3, 2022, indicated R20 received services including medication management, assistance with bathing, vital monitoring, laundry and housekeeping. The discharge summary indicated R20 required full medication management and setup and the licensed nurse was responsible for secure storage of the medications, monitoring supplies and reordering as needed. R20's discharge summary also included a Med (medication) Disposition Summary which was blank. On June 2, 2022, at approximately 9:23 a.m., licensed practical nurse (LPN)-A contacted registered nurse (RN)-H via telephone and verified the medication disposition form was blank and the record lacked documentation of the disposition of R20's medications upon discharge. RN-H stated no medication disposition was completed, "because she probably discharged when nobody was here, so the girls just gave them to her." The licensee's Disposition or Disposal of Medication policy, undated, indicated a resident's current medications that were secured or stored by the licensee would be given to the resident or the resident's representative when the resident's medication management services were terminated, and staff would document in the resident's record the name of the person to whom	{01910}		

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{01910}	Continued From page 67 the medications were given, the time and date, the name of each medication and the amount of medication remaining. Also included, staff would document the disposition or disposal of medications in the resident's record. No further information was provided.	{01910}		
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	{01940}		

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{01940}	Continued From page 68 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R6, R15) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: During the entrance conference of the follow-up survey on June 1, 2022, at approximately 9:08 a.m., licensed practical nurse (LPN)-A confirmed the licensee provided treatment management services to residents, including blood glucose checks, oxygen assistance and compression stockings. R6 R6's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel;	{01940}		

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{01940}	Continued From page 69 - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R6's Service Plan, signed May 17, 2022, indicated R6 required bathing assistance, behavior management, dressing, grooming, medication management, oxygen maintenance and blood glucose monitoring. R6's prescriber orders dated March 27, 2022, included glucose checks daily and as needed for signs/symptoms of hypoglycemia or hyperglycemia. R6's prescriber orders dated March 17, 2022, included oxygen at 2 liter/minute, continuously. On June 2, 2022, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-J administer oral medications and an inhaler for R6. R6 was sitting in her chair in her room and had nasal cannula in place with oxygen running. On June 3, 2022, at approximately 11:05 a.m., LPN-A verified the licensee had not developed a treatment management plan with the required content for R6. R15 R15's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided; - documentation of specific resident instructions	{01940}		

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{01940}	Continued From page 70 relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R15's Service Plan, signed May 17, 2022, indicated R15 received assistance with bathing, behavior management, medication administration, and blood glucose monitoring. R15's prescriber Insulin Management Regimen, dated May 9, 2022, included blood sugar testing before meals and at bedtime. On June 3, 2022, at approximately 11:05 a.m., LPN-A verified the licensee had not developed a treatment management plan with the required content for R15. In addition, LPN-A stated she did not find an individual treatment and therapy plan for any of the residents receiving those services and indicated the issue could be due to the electronic medical record process. A policy addressing the development of an individual treatment and therapy plan was requested but not provided. No further information was provided.	{01940}		

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{02310}	Continued From page 71	{02310}		
{02310} SS=I	144G.91 Subd. 4 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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for seven of seven residents (R1, R5, R6, R7, R14, R15, R16) with hospital beds with bedrails, and one of one resident (R13) with an assistive device. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order for correction on June 02, 2022. The findings include: HOSPITAL BEDS R1 On June 2, 2022, at approximately 11:15 a.m., the surveyor observed licensed practical nurse (LPN)-A and administrative assistant (AA)-K	{02310}	On June 03, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope of widespread and level three (I).	

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{02310}	Continued From page 72	{02310}		

measure R1's hospital bed bilateral bedrails. The bedrail on the right side of the bed was in the down position, the left side was up. The openings between the bars for zone 1, measured 3.5 inches. The measurements between the mattress and the bedrail for zone 3, measured 1.0 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 4 inches. The measurement from the mattress to the headboard for zone 7, measured 1.5 inches. LPN-A stated R1 doesn't usually have the bedrail on the right side of the bed up but uses it in the down position to pull herself up.

R1's diagnoses included epilepsy (seizures), depression, glaucoma, chronic pain, and generalized anxiety disorder.

R1's unsigned Service Plan, dated March 23, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing.

R1's medical record included education of the risks and benefits associated with the use of bedrails, signed February 10, 2022; however, lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the Food and Drug Administration (FDA) guidelines.

R5
On June 2, 2022, at approximately 11:17 a.m., the surveyor observed LPN-A and AA-K measure R5's hospital bed bilateral bedrails. The bedrails were in the up position. The openings between the bars for zone 1, measured 3.5 inches. The measurements between the mattress and the bedrail for zone 3, measured less than 1.0 inch.

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{02310}	Continued From page 73 The measurements between the top of the rail to the head of bed for zone 6 measured 2 inches. The measurements from the top of the mattress to the headboard for zone 7, measured .75 inches. R5 stated he used the bedrails for positioning and to get out of bed. R5's diagnoses included arthritis, arthrosis (degenerative disease) of hip, chronic low back pain, overactive bladder, and sleep apnea. R5's Service Plan, dated May 17, 2022, indicated R5 received services which included bathing assistance, behavior management, medication administration, blood glucose monitoring, housekeeping and laundry. R5's medical record lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines. R6 On June 2, 2022, at approximately 11:20 a.m., the surveyor observed LPN-A and AA-K measure R6's hospital bed bilateral bedrails. The bedrails were in the up position. The openings between the bars for zone 1, measured 4.5 inches. The measurements between the mattress and the bedrail for zone 3, measured less than 1.0 inch. The measurements between the top of the rail to the head of bed for zone 6 measured 3 inches. The measurements from the top of the mattress to the headboard for zone 7, measured .5 inches. R6's diagnoses included osteoarthritis, fibromyalgia (chronic muscle pain), depression, anxiety, sciatic pain, chronic knee pain, obesity, and stress incontinence.	{02310}		

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{02310}	Continued From page 74 R6's Service Plan, dated May 17, 2022, indicated R6 received services to include bathing assistance, behavior management, dressing, grooming, medication administration, oxygen maintenance, laundry and housekeeping. R6's medical record lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines and lacked education of the risks vs. benefits associated with the use of bedrails. R7 On June 2, 2022, at approximately 11:22 a.m., the surveyor observed LPN-A and AA-K measure R7's hospital bed bilateral bedrails. The bedrails were in the up position. The openings between the bars for zone 1, measured 2.5 inches. The measurements between the mattress and the bedrail for zone 3, measured 1.25 inches on the right side, and less than 1.0 inch on the left. The measurements between the top of the rail to the head of bed for zone 6 measured 5.0 inches on the left side, 6.0 inches on the right side. The measurements from the top of the mattress to the headboard for zone 7, measured 1.5 inches. LPN-A stated R7 was recently admitted for hospice services and the bedrails were installed yesterday, on June 1, 2022, by the medical equipment company per family's request. R7's diagnoses included dementia without behaviors and PICCS disease (irreversible form of dementia). R7's Service Plan, dated May 17, 2022, indicated R7 received services that included bathing assistance, dressing, eating, hygiene, grooming, mobility, and toileting.	{02310}		

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{02310}	Continued From page 75 R7's medical record lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines and lacked education of the risks vs. benefits associated with the use of bedrails. R14 On June 2, 2022, at approximately 11:25 a.m., the surveyor observed LPN-A and AA-K measure R14's hospital bed bilateral bedrails. The bedrails were in the up position. The openings between the bars for zone 1, measured 3.5 inches. The measurements between the mattress and the bedrail for zone 3, measured less than 1.0 inch. The measurements between the top of the rail to the head of bed for zone 6 measured 2.5 inches. The measurements from the top of the mattress to the headboard for zone 7, measured 3.0 inches. LPN-A stated R14 used the bedrails to turn from side to side. R14's diagnoses included multiple sclerosis, depression, insomnia, cognitive dysfunction, weakness, and chronic pain. R14's Service Plan, dated May 17, 2022, indicated R14 received services including bathing, dressing, eating, escorts, hygiene, grooming, mobility, and toileting. R14's medical record included education of the risks and benefits associated with the use of bedrails, signed February 10, 2022; however, lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines. R15 On June 2, 2022, at approximately 11:27 a.m., the surveyor observed LPN-A and AA-K measure	{02310}		

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{02310}	Continued From page 76 R15's single bedrail affixed on the left side of his bed. The bedrail measured 26 inches horizontally, with one horizontal bar through the middle of the opening. The openings between the bars for zone 1, measured 4.75 inches. The measurements between the mattress and the bedrail for zone 3, measured less than one inch. The measurements between the top of the compressed mattress and the bottom of the rail for zone 4, measured 3 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 7 inches. The measurements from the top of the mattress to the headboard for zone 7, measured less than 1 inch. R15 had diagnoses including seizure disorder. R15's Service Plan, dated May 17, 2022, indicated R15's services included behavior management, bathing assistance, blood glucose monitoring, housekeeping and laundry. R15's medical record included education of the risks and benefits associated with the use of bedrails, signed February 10, 2022; however, lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines. R16 On June 2, 2022, at approximately 11:30 a.m., the surveyor observed LPN-A and AA-K measure R16's hospital bed bilateral bedrails. The bedrails were in the up position. The openings between the bars for zone 1, measured 4.5 inches. The measurements between the mattress and the bedrail for zone 3, measured less than 1.0 inch. The measurements between the top of the rail to the head of bed for zone 6 measured 2.5 inches. The measurements from the top of the mattress	{02310}		

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{02310}	Continued From page 77 to the headboard for zone 7, measured 2.5 inches. R16's diagnoses included congestive heart failure, muscle weakness, type 2 diabetes, obesity, and urinary incontinence. R16's unsigned Service Plan, dated May 17, 2022, indicated R16 received services including ambulation/exercise program, bathing, dressing, grooming, mobility assistance, medication administration, blood glucose monitoring, toileting, housekeeping and laundry. R16's medical record lacked documentation of a bedrail assessment to include measurements to ensure the bedrails were consistent with the FDA guidelines and lacked education of the risks vs. benefits associated with the use of bedrails. ASSISTIVE DEVICE R13 On June 2, 2022, at approximately 11:35 a.m., the surveyor observed R13's bed to have a single square-shaped device, gray and black in color, on the right side (next to the wall) of her bed. The device was not affixed to the bed; however, had a strap attached that wrapped around the box spring and mattress. The device had a 4-inch opening and was snug against the mattress. R13 stated she used the device to get in and out of bed but wasn't currently using it because her bed had been moved and the device was currently on the wrong side; however, R13 stated she planned to switch the device to the other side of the bed so she could use it. R13's diagnoses included cerebral infarction (damage to brain tissue), concussion, bipolar	{02310}		

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{02310}	Continued From page 78 disorder, depression, and compression fracture of vertebra. R13's Service Plan, dated May 17, 2022, indicated R13 received services including bathing, dressing, eating, grooming, hygiene, mobility assistance, medication administration and toileting. R13's medical record lacked documentation of a bedrail assessment to ensure the device was safe and lacked education of the risks vs. benefits associated with the use of bedrails. In addition, R13's medical record lacked documentation that the device was installed per manufacturer's guidelines. On June 2, 2022, at approximately 11:40 a.m., LPN-A stated she was not aware that measurements needed to be included on the bedrail assessment, and stated she had risk and benefits signed by residents with bedrails during the initial survey but had not completed any since then for new residents or residents who had added bedrails since. LPN-A stated she had been in communication with registered nurse (RN)-H via text today during the follow up survey, and RN-H indicated she had conducted the bedrail assessments using R-Tasks (licensee's electronic medical record); however, RTasks did not include an area to document the measurements and RN-H stated she did not include the measurements because she had never been trained to do so. On June 2, 2022, at approximately 3:40 p.m., LPN-A stated she didn't know if R13's device was installed per manufacturer's guidelines because the medical equipment company installed it for the resident, and she had no information about it.	{02310}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
{02310}	Continued From page 79 The licensee's Side Rails policy, dated August 1, 2021, noted the RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rails, and verify the design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	{02310}		

Electronically Delivered

March 11, 2022

Administrator
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN 56379

RE: Project Number(s) SL33426015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-097

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33426015 On February 8, 2022, through February 11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 20 residents, all receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 8, 2022, at approximately 9:30 a.m., licensed practical nurse (LPN)-A and regional director of operations (RDO)-G stated they reviewed the regulations online.	0 250		

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0 250	Continued From page 3 The licensee attested they read and understood the Assisted Living licensing statutes and rules upon application. The licensee was issued an Assisted Living license, effective August 1, 2021. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Center for Disease Control and Prevention standards; - medication and treatment management; and -supervision of unlicensed personnel performing delegated tasks. Refer to licensing order at Statute 144G.60, Subd. 4. (a) The licensee failed to ensure two of three unlicensed personnel (ULP-D, ULP-F) completed training and competency evaluations in all required training topics. Refer to licensing order at Statute 144G.60, Subd. 4. (b) The licensee failed to ensure two of three unlicensed personnel (ULP-D, ULP-F) completed training and competency evaluations in all required training topics.	0 250		

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0 250	Continued From page 4 Refer to licensing order at Statute 144G.61, Subd. 2. (a) The licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel (ULP-E) with records reviewed. Refer to licensing order at Statute 144G.61, Subd. 2. (b) The licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel (ULP-E) with records reviewed. Refer to licensing order at Statute 144G.62, Subd. 4. The licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for one of three unlicensed personnel (ULP)-F) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure staff providing and supervising direct services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of five employees (registered nurse (RN)-H) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for four of four employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-D, ULP-E, ULP-F) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 5. The licensee failed to ensure employees received at least eight hours of annual training for	0 250		

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0 250	Continued From page 5 each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-E) with employee records reviewed. Refer to licensing order at Statute 144G.64 (a) 1-2. The licensee failed to ensure two of four employees (unlicensed personnel (ULP)-E, ULP-F) received the required amount of dementia care training, in the required time frame with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. (c-e). The licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed health history and symptom screening for three of five employees (registered nurse (RN)-H, licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-F), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for four of five employees (RN-H, LPN-A, ULP-D, ULP-F) with records reviewed. In addition, the licensee failed to ensure employees completed TB training for five of five employees (RN-H, LPN-A, ULP-D, ULP-E, ULP-F) with records reviewed. This had the potential to affect all residents, staff, and visitors. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted individualized	0 250		

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0 250	Continued From page 6 assessments to determine what medication management services would be provided and how the services would be provided for two of two residents (R1, R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to develop and maintain a current individualized medication management record for a resident to include all required content for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. (a; 2-4) (b). The licensee failed to ensure the registered nurse (RN) developed a written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to provide complete documentation of the medications sent with the resident for one of one resident (R1) who had an unplanned time away. This had the potential to affect all 20 residents who received medication management services. Refer to licensing order at Statute 144G.71, Subd. 13. The licensee failed to ensure prescriber orders were obtained for one of two residents (R1) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 14. The facility failed to renew prescriptions at least every 12 months for one of two residents (R2) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 19. The licensee failed to ensure refrigerated medications were maintained at manufactured recommended temperatures by failing to monitor and document medication	0 250		

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0 250	Continued From page 7 refrigerator temperatures, for two of two medication refrigerators (A, B). Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to date time-sensitive medications with an opened-on date for five of six residents (R4, R5, R6, R7, R8, and R9). In addition, the licensee failed to ensure medication containers had the original prescription label for two of six residents (R4 and R6) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with records reviewed. Forty-three (43) correction orders were issued, which indicated the licensee's understanding of the Minnesota Statutes and Rules were limited or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 8 (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 observation, interview and record review, the licensee failed to develop and post the required staffing plan potentially affecting the licensee's 20 current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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 9 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 held an assisted living facility license with a bed capacity of 27 residents; current census was 20 residents. STAFF POSTING On Feb 9, 2021, at approximately 9:25 a.m., the regional director of operations (RDO)-G showed the surveyor the staff posting on the first floor, on a white board in the unlicensed personnel (ULP) desk area. The desk area was in a hallway behind the receptionist's desk, and not in a central location accessible to residents and the public, as required. The white board had held magnetic strips with ULP names, and staff were to move the appropriate names under the appropriate shift each day; however, the names were not correct for the current shift. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 10 - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. On February 11, 2022, at approximately 1:56 p.m., RDO-G indicated the licensee had not developed a staffing plan and stated, "That is something I've been saying we need." The licensee lacked a policy regarding the staff posting and staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 480	Continued From page 11 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 8, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 485		

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0 485	Continued From page 12 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all 20 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 11, 2022, at approximately 10:23 a.m., licensed practical nurse (LPN)-A stated they had recently hired new kitchen staff who was developing menus with input from the residents.	0 485		

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0 485	Continued From page 13 LPN-A provided a handwritten document she referred to as the menu being developed; however, verified the current menu was not available to residents at least one week in advance. LPN-A stated the upcoming meal was written on the white board in the dining room. The licensee's Food Service policy, dated 2021, indicated menus should be planned in advance and followed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as the contact information for the Office of Ombudsman for Mental Health and Development Disabilities. This	0 550		

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0 550	Continued From page 14 had the potential to affect all 20 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on February 8, 2022, at approximately 10:32 a.m., the surveyor observed the licensee's grievance procedure posted on the first floor located near the receptionist desk. The posted grievance procedure lacked the required name and email of the individuals who were responsible for handling resident grievances and the contact information for the Office of Ombudsman for Mental Health and Development Disabilities. On February 10, 2022, at approximately 8:05 a.m., licensed practical nurse (LPN)-A confirmed the required content noted above was not posted. The licensee's Grievance Policy dated 2020, indicated if a resident and/or the family/designated [representative] was not satisfied with the response of the administrator they could contact the management company's main office. The corporate team would investigate the grievance and follow up with resident and/or the family/designated [representative] in a timely manner: Contact information for the corporate office was listed as follows:	0 550		

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0 550	Continued From page 15 -title of management company; -address of management company; and -phone number of management company. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility. This had the potential to affect all 20 current residents, staff, and visitors. 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 the residents). The findings include: On February 8, 2022, at approximately 9:00 a.m., upon entering the facility, the surveyor did not observe the license posted at the facility main entrance.	0 570		

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0 570	Continued From page 16 On February 8, 2022, at approximately 10:30 a.m., during a self-guided facility tour, the surveyor observed the license hanging on the inside wall of the enclosed receptionist desk area. The license was not clearly visible by visitors or residents. During an interview on February 9, 2022, at approximately 9:25 a.m., regional director of operations (RDO)-G verified the license was not visible to visitors or residents in its current location. The licensees' Assisted Living License and Posting policy dated August 1, 2021, indicated a current Assisted Living License issued by the Minnesota Department of Health would be posted at the common area clearly visible by all visitors and residents of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630		

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0 630	Continued From page 17 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of two residents (R1) with records reviewed. 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 record lacked a list of R1's diagnoses. R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry, and assistance with bathing. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. R1's IAPP, dated February 8, 2022, was completed on February 8, 2022, following the state surveyor's request to review the document.	0 630		

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0 630	Continued From page 18 On February 9, 2022, at approximately 4:21 p.m., regional director of operations (RDO)-G stated she was unable to locate a completed IAPP prior to the one dated February 8, 2022. RDO-G confirmed the registered nurse (RN) completed R1's IAPP after the state surveyor requested the document. On February 11, 2022, at approximately 9:28 a.m., RN-H verified she completed R1's IAPP on February 8, 2022, after state surveyors entered the building and requested the document. RN-H confirmed R1's IAPP should have been completed upon admission. The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, indicated the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The plan would contain the following: -an individualized review or assessment of the person's susceptibility to abuse by another individual, including: -other vulnerable adults; -the person's risk of abusing other vulnerable adults; -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults; and -for purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 650	Continued From page 19	0 650		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for four of five	0 650		

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0 650	Continued From page 20 employees (licensed practical nurse (LPN)-E, registered nurse (RN)-H, and unlicensed personnel (ULP)-D and ULP-E) with records reviewed. 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: LPN-A LPN-A started employment on October 19, 2021. LPN-A's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. RN-H RN-H started employment on January 12, 2022. RN-H's employee record lacked the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. ULP-D ULP-D had a start date of September 27, 2019, and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked the following:	0 650		

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0 650	Continued From page 21 - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and -documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-E ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. ULP-E's employee's record lacked evidence of the following: -documentation of annual performance reviews that identify areas of improvement needed and training needs. On February 11, 2022, at approximately 12:36 p.m., regional director of operations (RDO)-G verified the above contents were missing from the employees' records. The licensee's Employee Files policy, dated August 1, 2021, indicated employee records for each person would include: -evidence of current professional licensure, registration or certificate, if required; -records of all training and in-service education required and/or provided including record of competency testing as required; -current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any; -documentation of annual performance reviews that identify areas of improvement needed and training needs; -for individuals providing Assisted Living services, verification that required health screenings for tuberculosis have taken place and the dates of	0 650		

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0 650	Continued From page 22 those screenings; -documentation of a completed background study; -evidence that a reference check has been completed; and -verification of completed orientation and annual training and competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 23 for Disease Control and Prevention (CDC). This included documentation of a completed health history and symptom screening for three of five employees (registered nurse (RN)-H, licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-F) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for four of five employees (RN-H, LPN-A, ULP-D, ULP-F) with records reviewed. In addition, the licensee failed to ensure employees completed TB training for five of five employees (RN-H, LPN-A, ULP-D, ULP-E, ULP-F) with records reviewed. This had the potential to affect all 20 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility Tuberculosis (TB) Risk Assessment dated August 1, 2021, indicated a low risk level. RN-H RN-H started employment on January 12, 2022. RN-H's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required.	0 660		

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0 660	Continued From page 24 LPN-A LPN-A started employment on October 19, 2021. LPN-A's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-D ULP-D started employment on September 27, 2019, and began providing assisted living services on August 1, 2021. ULP-D's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCW), dated August 20, 2021, that included TB health history and symptom screening; however, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. ULP-E ULP-E started employment on August 21, 2019, and began providing assisted living services on August 1, 2021. ULP-E's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCW), dated September 19, 2019, and October 10, 2019, that included TB health history and symptom screening and evidence of baseline screening for presence of TB infection with negative results; however, lacked evidence of TB training at time of hire, as required. ULP-F ULP-F started employment on August 1, 2021.	0 660		

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
0 660	Continued From page 25 ULP-F's employee record lacked evidence of completed TB health history and symptom screening, lacked evidence of baseline screening for presence of TB infection and lacked evidence of TB training at time of hire, as required. The licensee's Tuberculosis Screening policy, dated August 1, 2021, lacked identification of an individual staff member with primary responsibility for the TB infection control program. The policy indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCW's and would have a blood test or a two-step tuberculin skin test. The policy directed no staff would be permitted to begin work where the work involved sharing the air space with residents until the negative results of the blood test or the first tuberculin skin test were read and documented. In addition, staff TB screening results would be kept in each employee medical file. Further, the policy indicated staff would be educated regarding TB at the time of hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." No further information was provided.	0 660		

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0 660	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content. This	0 680		

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0 680	Continued From page 27 had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 8, 2022, at 9:25 a.m., survey staff requested from licensed practical nurse (LPN)-A and regional director of operations (RDO)-G to view the facility's emergency preparedness plan. The Emergency and Disaster Manual contained blank templates for an emergency preparedness plan and were not completed per requirements. On February 8, 2022, at 10:32 a.m., during a self-guided facility tour the surveyor observed no information posted regarding an emergency preparedness plan throughout common areas of the facility. On February 8, 2022, at approximately 10:48 a.m., RDO-G stated they stored the emergency preparedness manual inside the receptionist desk area and confirmed it was not readily available for visitors or residents to view. RDO-G further confirmed there was no posting in the facility regarding the emergency plan except for the emergency exits signs. On February 10, 2022, at 4:12 p.m., RDO-G returned the Emergency and Disaster manual to surveyor. After second review of the manual,	0 680		

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0 680	Continued From page 28 sections of the template were completed with emergency contact numbers which were previously blank when surveyor reviewed the Emergency and Disaster manual on February 8, 2022. RDO-G confirmed the Emergency and Disaster manual was not completed prior to surveyors' entrance on February 8, 2022, and the templates were being completed during time of the survey. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan. The intent was for the plan to align with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		
0 690 SS=A	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	0 690		

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0 690	Continued From page 29 Based on interview and record review, the licensee failed to ensure a resident's admission assessment was authenticated with the name and title of the person who completed the assessment and lacked the date the assessment was completed for one of two residents (R1) with records reviewed. 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 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 admission assessment was undated and was not authenticated with the name and title of the person who completed the assessment. On February 11, 2022, at approximately 9:00 a.m., the licensed practical nurse (LPN)-A verified R1's admission assessment did not include the name and title of the person who completed the assessment and did not include the date the assessment was completed. On February 11, 2022, at approximately 9:28 a.m., registered nurse (RN)-I confirmed she completed R1's admission assessment and was unsure why the assessment did not include her name, title or date the assessment was completed. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment	0 690		

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0 690	Continued From page 30 must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730		

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0 730	Continued From page 31 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a resident record contained health information to include medial history of the resident's diagnoses for one of two residents (R1) with record reviewed. 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:	0 730		

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0 730	Continued From page 32 R1 was admitted on November 19, 2021. R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services including medication administration, housekeeping, laundry, and assistance with bathing. R1's record lacked health information to include R1's diagnoses. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. On February 11, 2022, at approximately 9:04 a.m., licensed practical nurse (LPN)-A verified R1's record lacked a complete medical history to include a list of R1's diagnoses. LPN-A stated she reviewed R1's complete record and could not find any documentation of R1's diagnoses. The licensee's Resident Record - Information and Content policy dated August 1, 2021, indicated resident records must include health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 33 (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 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 the potential to affect a large portion or all residents). The findings include: On February 08, 2022, from approximately 10:15 a.m. to 12:00 p.m., survey staff toured the facility with the owners (O)-C and (O)-B. During the facility tour, survey staff observed the following: 1. In the first-floor laundry room there was a shelf obstructing the sprinkler head. Sprinkler heads require a minimum of 18" clear to function properly. 2. In the first-floor electrical room items were being stored in front of the electrical panels.	0 800		

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0 800	Continued From page 34 Electrical panels require a 3'-0" clear space in front of them. 3. The door to the tub room was damaged and the inside material was exposed. O-C stated the damage was caused by a wheelchair. 4. First-floor exit stair was being used as additional storage for items left behind by families. Egress paths must be maintained clear for exiting at all times. O-C and O-B verbally confirmed survey staff observations during the facility tour. O-B stated they would take care of the above-listed items immediately. Staff was observed removing stored items from the above locations during the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 35 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 interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, 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 the potential to affect a large portion or all residents). The findings include:	0 810		

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0 810	Continued From page 36 During the interview on February 08, 2022, at 12:30 p.m. the licensed practical nurse (LPN)-A stated she had just received the official paperwork from the corporate office but had not done the evacuation plan for this facility. Review of the Emergency and Disaster Manual showed the following were missing from the Fire on Premises section: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820	Continued From page 37	0 820		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all facility elements, including oxygen storage and sprinkler system coverage, does not create a distinct hazard to residents and staff. 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, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On February 08, 2022, from approximately 10:15 a.m. to 12:00 p.m., survey staff toured the facility	0 820		

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0 820	Continued From page 38 with the owners (O)-C and (O)-B. During the facility tour, survey staff observed 56 oxygen storage cylinders. Some of the cylinders were not properly stored in racks or by chains. Additional oxygen cylinders were found in a resident room. The oxygen in the resident room was not properly stored in racks or by chains. Recommendation made to contact the local fire code official for education and resources on oxygen storage. During the same facility tour, survey staff observed there were no sprinkler heads under the screened-in patio used for smoking. O-C and O-B verbally confirmed survey staff observations during the facility tour. O-C and O-B stated they did a full renovation when they purchased the property, including the addition of a sprinkler system, but did not modify anything on the existing screened-in porch. Recommendation made to contact the local fire code official for resources on fire code and sprinkler systems. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 820		
0 900 SS=C	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	0 900		

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0 900	Continued From page 39 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. (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 provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all 20 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	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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0 900	Continued From page 40 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services including medication administration, housekeeping, laundry, and assistance with bathing. R1's record included a signed copy of an assisted living contract dated November 19, 2021. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. On February 10, 2022, at approximately at 5:09 p.m., the regional director of operations (RDO)-G stated they were unable to provide evidence an unsigned copy of the contract was provided to the Office of Ombudsman for Long-Term Care, as required. The licensee's policy, Signing an Assisted Living Contract, dated August 1, 2021, indicated a signed Assisted Living contract must be signed and received by the licensee when a prospective resident decided to move in; however, the policy lacked direction to provide an unsigned copy of the contract to the Office of Ombudsman for Long-Term Care, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 41 (21) days	0 900		
0 910 SS=A	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of two residents (R1) with records reviewed. 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 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 record lacked an assisted living contract to include the license number of the facility.	0 910		

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0 910	Continued From page 42 R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services including medication administration, housekeeping, laundry, and assistance with bathing. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. On February 10, 2022, at approximately at 5:09 p.m., the regional director of operations (RDO)-G verified R1's assisted living contract did not include the license number of the facility. The licensee did not have a written policy on the assisted living contract requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=A	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional	0 920		

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0 920	Continued From page 43 fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. 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 one of two residents (R1) with records reviewed. 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 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 record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry, and assistance with bathing. R1's assisted living contract signed November	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 920	Continued From page 44 19, 2021, lacked the following content: -billing and payment procedures and requirements. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. On February 10, 2022, at approximately at 5:09 p.m., the regional director of operations (RDO)-G verified R1's assisted living contract did not include the billing and payment procedures and requirements and further verified on page three of R1's contract the schedule monthly fee amount and dates were blank. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated when a prospective resident is ready to sign a lease and move in, fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and	0 930		

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0 930	Continued From page 45 conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; 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) with records reviewed. This had the potential to affect all 20 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services including	0 930		

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0 930	Continued From page 46 medication administration, housekeeping, laundry, and assistance with bathing. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. R1's assisted living contract signed November 19, 2021, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and -the resident's right to obtain services from an unaffiliated service provider. R2 R2's record lacked a Service Plan; however, R2's "planned services" dated August 18, 2021, indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E seated beside R2's wheeled support chair at the table in the dining room, assisting R2 to eat her breakfast, bringing spoonfuls of hot cereal to R2's mouth. R2's assisted living contract signed August 23,	0 930		

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0 930	Continued From page 47 2021, lacked the following content: -the name and contact information of the person representing the facility who is designated to handle and resolve complaints; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; -contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and -the resident's right to obtain services from an unaffiliated service provider. On February 10, 2022, at approximately at 5:09 p.m., the regional director of operations (RDO)-G confirmed the contract provided in the admission packet was the same contract used for all residents. RDO-G confirmed the contract lacked the required content as noted above, and further stated contracts would have to be updated for all residents in the facility. The licensee did not have a written policy for the assisted living contract requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 48 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 8, 2022, at approximately 9:30 a.m., the surveyor requested a copy of the facility's assisted living contract. The assisted living contract included a clause on page 10, section 12, that indicated the resident agreed to hold harmless the licensee, the management company, and each other party that it had engaged to assist in the operation of the licensee or render services to the resident, and would waive the licensee's liability for all damages, injuries and losses of whatever nature and whatever cause, excluding willful and negligent acts, including but not limited to,	0 970		

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0 970	Continued From page 49 fulfillment of lease provisions, casualty fire, natural disaster, failure of essential services, utilities and acts of third parties which may adversely affect residents use of premises. Further the clause included, the resident agreed not to attempt to collect damages of any sort from the licensee, the management company, or any other party that the licensee had engaged to assist in the operation of the licensee or render services to the resident, or their respective insurance carriers, nor file any action-at-law regarding such matters. On February 10, 2022, at approximately 5:25 p.m., regional director of operations (RDO)-G confirmed the assisted living contract required the above content and stated the same contract was utilized for all residents at the facility. The licensee's policy, Signing an Assisted Living Contract, dated August 1, 2021, directed to emphasize to the prospective resident and/or responsible person that the assisted living contract was a legal, binding contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01320 SS=E	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or	01320		

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01320	Continued From page 50 (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three unlicensed personnel (ULP-D, ULP-F) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 had a hire date of September 27, 2019, and began providing assisted living services on August 1, 2021.	01320		

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01320	Continued From page 51 ULP-D's record lacked documentation of completed training and competency testing in topics listed in 144G.61 subdivision 2, paragraph (a). ULP-F ULP-F had a hire date of August 1, 2021. ULP-F's record included a Delegated Procedures Competency Check-Off, undated; however, the document was blank. ULP-F's record lacked documentation of completed training and competency testing in topics listed in 144G.61, subdivision 2, paragraph (a). On February 10, 2022, at 4:46 p.m., regional director of operations (RDO)-G and licensed practical nurse (LPN)-A verified ULP-D and ULP-F performed assisted living services and confirmed ULP-D and ULP-F's records lacked evidence of completed training and competency testing in topics noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated prior to performing assisted living services, the registered nurse must make certain the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each client and were able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01320		

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01330	Continued From page 52	01330		
01330 SS=E	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three unlicensed personnel (ULP-D, ULP-F) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01330		

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01330	Continued From page 53 found to be pervasive). The findings include: ULP-D ULP-D had a hire date of September 27, 2019, and began providing assisted living services on August 1, 2021. ULP-D's record lacked documentation of completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks she would perform. ULP-F ULP-F had a hire date of August 1, 2021, to provide assisted living services. ULP-F's record included a Delegated Procedures Competency Check-Off, undated; however, the document was blank. ULP-F's record lacked documentation of completed training and demonstrated competency by completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks she would perform. On February 10, 2022, at 4:46 p.m., regional director of operations (RDO)-G and licensed practical nurse (LPN)-A verified ULP-D and ULP-F performed assisted living services and delegated nursing tasks and confirmed ULP-D	01330		

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	33426	A. BUILDING: _____ B. WING _____	02/11/2022

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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01330	Continued From page 54 and ULP-F's records lacked evidence of completed training and demonstrated competency by completing a written or oral test of the topics as noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated prior to performing assisted living services and delegated tasks, the registered nurse must make certain the unlicensed personnel was trained in the proper methods to perform the tasks or procedures for each client and were able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01370		

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01370	Continued From page 55 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel (ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01370		

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01370	Continued From page 56 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E's employee record lacked evidence to indicate the employee completed training and/or competency evaluations as required in the following areas: -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; and -awareness of confidentiality and privacy. ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed ULP-E seated beside R2's wheeled support chair at the table in the dining room assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. ULP-E's employee's record contained documents which listed training and demonstration topics; however, the form lacked information related to the above required training. On February 10, 2022, at 4:46 p.m., regional director of operations (RDO)-G and licensed practical nurse (LPN)-A verified ULP-E performed assisted living services and delegated nursing tasks and confirmed ULP-E's record lacked the required content noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would	01370		

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01370	Continued From page 57 include: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise and treatment reminders; -basic nutrition, meal preparation, food safety and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		

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01380	Continued From page 58	01380		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel (ULP-E) with records reviewed. 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).	01380		

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01380	Continued From page 59 The findings include: ULP-E's employee record lacked evidence to indicate the employee completed training and/or competency evaluations as required in the following areas: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -range of motioning and positioning. ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed ULP-E seated beside R2's wheeled support chair at the table in the dining room assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. ULP-E's employee's record contained documents which listed training and demonstration topics; however, lacked information related to the above required training. On February 10, 2022, at 4:46 p.m., regional director of operations (RDO)-G and licensed practical nurse (LPN)-A verified ULP-E performed assisted living services and delegated nursing tasks and confirmed ULP-E's record lacked the required content noted above. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all ULPs would	01380		

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01380	Continued From page 60 include: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	01440		

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01440	Continued From page 61 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for one of three unlicensed personnel (ULP)-F) with records reviewed. 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-F had a hire date of August 1, 2021. ULP-F's record lacked evidence an RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks. On February 10, 2022, at 4:46 p.m., regional director of operations (RDO)-G and licensed practical nurse (LPN)-A verified ULP-F performed assisted living services and delegated nursing tasks and verified the RN did not supervise	01440		

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01440	Continued From page 62 ULP-F performing a delegated nursing task within 30 days as required. The licensee's Supervision of Staff-Delegated Services policy, dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing and supervising direct services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of five employees (registered nurse (RN)-H) with records reviewed. This practice resulted in a level two violation (a	01460		

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01460	Continued From page 63 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 8, 2022, at approximately 3:08 p.m., regional director of operations (RDO)-G stated the licensee employed RN-H to cover on-call from 6:00 p.m. to 6:00 a.m., and she would come to the facility if needed because she lived in the area. RN-H had a hire date of January 12, 2022. RN-H's record lacked evidence of completing orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On February 10, 2022, at approximately 4:46 p.m., RDO-G confirmed RN-H did not receive the orientation to assisted living facility licensing requirements and regulations. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided.	01460		

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01460	Continued From page 64 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 65 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for four of four employees (licensed practical nurse (LPN)-A, unlicensed personnel (ULP)-D, ULP-E, ULP-F) with records reviewed. 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	01470		

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01470	Continued From page 66 a large portion or all of the residents). The findings include: LPN-A, ULP-D, ULP-E and ULP-F's records lacked evidence to indicate the employees received orientation to include the required topics. LPN-A LPN-A started employment on October 19, 2021. LPN-A's record lacked the following required content: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -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. ULP-D	01470		

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01470	Continued From page 67 ULP-D had a start date of September 27, 2019, and began providing assisted living services on August 1, 2021. ULP-D's record lacked the following required content: -an overview of this chapter; -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; -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. ULP-E ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. ULP-E's record lacked the following required content: -an overview of this chapter; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F	01470		

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01470	Continued From page 68 ULP-F had a hire date of August 1, 2021, to provide assisted living services. ULP-F's record lacked the following required content: -an overview of this chapter; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On February 10, 2022, at approximately 4:46 p.m., regional director of operations (RDO)-G confirmed the above missing contents and stated she was fairly new to her position and did not know who was responsible for staff orientation or what the orientation consisted of. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated all staff must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents, and must contain the following topics: -an overview of the appropriate Assisted Living statutes and rules; -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	01470		

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01470	Continued From page 69 and protection of those rights; -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; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; -the staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed; -the facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and -the identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01500	Continued From page 70	01500		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services 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	01500		

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01500	Continued From page 71 providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-E) with employee records reviewed. 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).	01500		

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01500	Continued From page 72 The findings include: ULP-D ULP-D had a start date of September 27, 2019, and began providing assisted living services on August 1, 2021. ULP-E ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. ULP-D and ULP-E's employee training records lacked evidence ULP-D and ULP-E successfully completed annual training as required, in the following areas: -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 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	01500		

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01500	Continued From page 73 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 10, 2022, at approximately 5:02 p.m., regional director of operations (RDO)-G confirmed ULP-D and ULP-E lacked annual training. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff performing direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, and must include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557. 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. 6. Principles of person-centered planning and	01500		

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01500	Continued From page 74 service delivery and how they apply to direct support services provided by the staff person. The policy also indicated the licensee would retain a training record in the employee records to track compliance with annual training requirements. 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 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	01530		

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01530	Continued From page 75 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-E, ULP-F) received the required amount of dementia care training, in the required time frame with records reviewed. 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: The licensee provided services under an assisted living license. During the entrance conference on February 8, 2022, at approximately 10:00 a.m., licensed practical nurse (LPN)-A stated the licensee currently had no residents with the diagnosis of dementia; however, had the potential to care for residents with a dementia diagnosis. ULP-E ULP-E had a start date of August 21, 2019, and began providing assisted living services on August 1, 2021. ULP-E reached 160 working hours on September 11, 2021.	01530		

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01530	Continued From page 76 On February 9, 2022, at approximately 9:00 a.m., the surveyor observed ULP-E seated beside R2's wheeled support chair at the table in the dining room assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. R2's diagnoses included dementia, anxiety, major depressive disorder and palliative care. ULP-E's record had no documentation of dementia care training, therefore less than the required 8 hours required within 160 working hours. ULP-F ULP-F started employment on August 1, 2021. ULP-F reached 160 working hours on September 20, 2021. ULP-F's record had no documentation of dementia care training, therefore less than the required 8 hours required within 160 working hours. On February 10, 2022, at approximately 4:52 p.m., regional director of operations (RDO)-G confirmed the employees lacked the required amount of initial training in dementia care. The licensee's Dementia Training policy dated August 1, 2021, indicated direct care employees would complete 8 hours of initial training within 160 hours of the employment start date and two hours of additional training for each 12 months of work thereafter. Further, required dementia training topics included an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors,	01530		

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01530	Continued From page 77 communication skills and person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620		

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01620	Continued From page 78 licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2 was admitted for services on March 17, 2017. R2's assisted living contract was signed by her representative on August 23, 2021. R2's record lacked a Service Plan; however, included document titled Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E seated beside R2's wheeled support chair at the table in the dining room assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. R2's record included three assessments titled Assessment As Of Date, dated March 15, 2021, June 11, 2021 and February 9, 2022 (243	01620		

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01620	Continued From page 79 calendar days from the date of the last review), completed after survey entrance and after the surveyor's request for the document. On February 11, 2022, licensed practical nurse (LPN)-A verified comprehensive reassessments were not always completed at least every 90 days, as required. LPN-A also verified registered nurse (RN)-I completed R2's comprehensive assessment after the surveyor entered and requested the information. The licensee's Assessment, Reviews & Monitoring policy, dated August 1, 2021, indicated ongoing resident reassessment and monitoring must be conducted by the RN, as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 80 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans were developed and implemented for three of three residents (R1, R2, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, and R4's records lacked evidence the licensee had developed a current service plan. R1 R1 was admitted on November 19, 2021. R1's record lacked a list of R1's diagnoses.	01640		

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01640	Continued From page 81 R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medications. R2 R2 was admitted to services on March 17, 2017. R2's diagnoses included dementia, anxiety, major depressive disorder and palliative care. R2's record lacked a Service Plan; however, included document titled Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed ULP-E seated beside R2's wheeled support chair at the table in the dining room, assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. R4 R4 was admitted on January 25, 2018. R4's diagnoses included diabetes, hypothyroidism (underactive thyroid), chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood	01640		

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01640	Continued From page 82 pressure), arthritis, depression and anxiety. R4's record lacked a service plan; however, R4's Individual Medication Management Plan dated December 13, 2021, indicated R4 received services to include medication administration. R4's Resident Profile printed February 11, 2022, indicated R4 received services for medication management, housekeeping, laundry and bathing. On February 9, 2022, at approximately 8:03 a.m., the surveyor observed ULP-F administering R4's morning medications. On February 9, 2022, at approximately 3:18 p.m., Regional Director of Operations (RDO)-G confirmed R1, R2 and R4 did not have a service plan in place and the "planned services" was being used as the resident's service plan. RDO-G verified the "planned services" did not meet the requirements outlined in the licensee's Service Plan policy. On February 9, 2022, at approximately 4:21 p.m., licensed practical nurse (LPN)-A stated the "planned services" document was used as the resident's service plan and care plan. LPN-A confirmed the residents did not have a service plan that met the requirements. The licensee's Service Plan policy dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place. The policy further indicated within 14 days after the date that services were first provided to a resident, the licensee would finalize a written service plan. A service plan would include: -a description of the services that are to be	01640		

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01640	Continued From page 83 provided based on the most recent assessment and resident preferences; -fees for services to be provided; -the frequency of each service to be provided based on the most recent assessment and resident preferences; -an identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.); -a schedule and method for the next planned assessment or monitoring; -a schedule and method for the next planned monitoring of staff providing services; and -a contingency plan that includes: -actions Cornerstone Management Services will take if scheduled services cannot be provided -information regarding how the resident can contact Cornerstone Management Services; -the names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; -identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and -how the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services	01700		

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01700	Continued From page 84 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted individualized assessments to determine what medication management services would be provided and how the services would be provided for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01700		

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01700	Continued From page 85 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 8, 2022, at approximately 9:25 a.m., the licensed practical nurse (LPN)-A and regional director of operations (RDO)-G confirmed the licensee provided medication management services to residents. R1 and R2's records lacked evidence the RN conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking. R1 R1's record lacked a service plan; however included document titled Planned Services dated February 9, 2022, and indicated R1 received services including medication administration, housekeeping, laundry and assistance with bathing. R1's Individual Medication Management Plan dated February 9, 2022, indicated R1 was independent with medication administration and was able to manage and self-administer medications safely. R1's Individual Medication Management Plan further indicated R1 had difficulty seeing and the licensee took over R1's medications and R1 was no longer to self-administer medications.	01700		

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01700	Continued From page 86 R1's comprehensive assessment dated February 8, 2022, indicated R1 was independent with medication administration and managed own medications including set up and ordering. R1's assessment also indicated R1 had difficulty seeing and the licensee took over medication management due to suspicions of drug diversion and missed medications. R1's January and February 2022, Medication Administration Summary, listed the medications as prescribed, times to administer, and staff initials indicating the medications were administered. On February 10, 2022, at approximately 10:13 a.m., licensed practical nurse (LPN)-A confirmed the licensee was managing and administering R1's medications after the first couple of weeks of R1's admission. LPN-A confirmed R1's Individual Management Plan or comprehensive assessment was not up to date and did not reflect current medication services being provided for R1. R2 R2's assisted living contract was signed by her representative on August 23, 2021. R2's record lacked a Service Plan; however, included document titled Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration. R2's Individual Medication Management Plan dated February 8, 2022, lacked the above required content.	01700		

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01700	Continued From page 87 R2's prescriber orders dated January 25, 2021, included one oral medication to treat agitation, two pain medications, one sleep aid and one antidepressant. R2's January 2022 and February 2022, Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials on each date to indicate the medications had been given. On February 11, 2022, at approximately 10:36 a.m., LPN-A verified R2's Individual Medication Management Plan lacked an identification and review of all medications R2 was known to be taking. The licensee's Medication Management - Assessment, Monitoring & Reassessment dated August 1, 2021, indicated the assessment must include an identification and review of all medications the resident is known to be taking. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 88 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for a resident to include all	01730		

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01730	Continued From page 89 required content for one of one resident (R1) with record reviewed. 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: During the entrance conference on February 8, 2022, at approximately 9:25 a.m., the licensed practical nurse (LPN)-A and Regional Director of Operations (RDO)-G confirmed the licensee provided medication management services to residents residing at the facility. R1's record lacked a list of R1's diagnoses. R1's record lacked a service plan; however, R1's document titlled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing. R1's record lacked signed prescriber orders. R1's comprehensive assessment dated December 22, 2021, indicated R1was able to safely self-administer medications. R1's assessment further indicated R1 had difficulty seeing and the licensee took over R1's medications and R1 was no longer to self-administer medications.	01730		

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01730	Continued From page 90 R1's Individual Medication Management Plan dated February 9, 2022, indicated R1 was independent with medication administration and was able to manage and self-administer medications safely. R1's Individual Medication Management Plan further indicated R1 had difficulty seeing and the licensee took over R1 medications and R1 was no longer to self-administer medications. On February 8, 2022, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's scheduled medications. R1's medication administration record (MAR), dated January 1 through February 9, 2022, indicated the following medications were administered: -Klonopin 0.5 milligrams (mg) twice daily for symptoms of seizures and panic disorder; -fluoxetine hcl 40 mg one capsule twice a day for depression, panic attacks, and obsessive-compulsive disorder; -acetaminophen 500 mg two tablets three times a day for pain management; -artificial tears 1.4 percent one drop to both eyes every four hours as needed. Self-administration; -furosemide (a diuretic) 20 mg one tablet daily; -hydrocodone-acetaminophen 5 mg/325 mg one table daily for moderate pain; -hydrochlorothiazide 12.5 mg one tablet every morning for high blood pressure; -latanoprost one drop in each eye daily for glaucoma; -metoprolol succinate er 50 mg one tablet daily for high blood pressure; -prednisone 15 mg one tablet daily for pain; -pregabalin 75 mg one capsule daily for nerve pain;	01730		

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01730	Continued From page 91 -Prozac 40 mg one tablet daily for depression; -Rifampin 300 mg one tablet twice a day to treat tuberculosis; -Topamax 200 mg one tablet daily for epilepsy; -Tylenol 500 mg two tablets three times a day for pain management-self administration; -Zofran 8 mg one tablet once per week before Vitamin-D is given on Thursday; -Zyrtec 10 mg one tablet daily to treat allergy symptoms; -vitamin b 12 injection 1000 mcg/ml one time per month; -vitamin d 1.25 mg one capsule once a week on Thursdays; and -Xarelto 15 mg one tablet daily for chronic atrial fibrillation. On February 10, 2022, at approximately 10:13 a.m., licensed practical nurse (LPN)-A confirmed the licensee was managing and administering R1's medications. LPN-A confirmed R1's Individual Management Plan was not up to date and did not reflect current medication services being provided for R1. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment and would be updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01760	Continued From page 92	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed and administered according to manufacturer's instructions for one of two residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included diabetes,	01760		

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01760	Continued From page 93	01760		

hypothyroidism (underactive thyroid), chronic obstructive pulmonary disease (COPD) (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure), arthritis, depression and anxiety.

R4's record lacked a service plan; however, R4's Individual Medication Management Plan dated December 13, 2021, indicated R4 received services which included medication administration.

R4's prescriber orders included levothyroxine (treat underactive thyroid) 50 micrograms (mcg) one tablet by mouth once daily. Do not give with morning medications, must be given separately before rest of medications by mouth. In addition, Wixela (inhaler to prevent wheezing) 250-50 micrograms (mcg) Inhub inhale one puff twice a daily. Remind resident to rinse mouth after using inhaler.

On February 9, 2022, at approximately 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-F conduct a medication pass for R4, which included administration of oral medications and the Wixela inhaler. ULP-F handed the inhaler to R4; the resident activated the inhaler; released one puff of the inhaler into her mouth and took a long, fast breath in; R4 handed the inhaler back to ULP-F. ULP-F did not instruct the resident to rinse her mouth out after the administration of the inhaler. ULP-F proceeded to administer R4's morning oral medications including levothyroxine then R4 washed oral medications down with water.

On February 9, 2022, at approximately 8:10 a.m., immediately following the above medication pass observation, ULP-F confirmed she had not

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01760	Continued From page 94 instructed R4 to rinse her mouth out following administration of the Wixela inhaler. ULP-F stated she was unaware it was necessary; however, ULP-F confirmed the directions on the medication administration record (MAR) for Wixela inhaler was to remind the resident to rinse mouth out after using the inhaler. ULP-F confirmed she administered R4's levothyroxine along with the rest of her scheduled morning medications and further stated R4 preferred all of her morning medications to be given at once. ULP-F confirmed R4's MAR instructed levothyroxine not to be given with morning medications and must be given separately before rest of medications by mouth. On February 11, 2022, at approximately 9:55 a.m., licensed practical nurse (LPN)-A confirmed the manufacturer's instructions for inhaler administration should be followed, and R4 should have been reminded to rinse her mouth out after administration of her Wixela inhaler. LPN-A further stated she expected prescriber orders to be followed as directed and ULP-F should not have administered R4's levothyroxine with all of her other oral morning medications as directed. The manufacturer's instructions for use of the Wixela Inhub inhaler revised date March 2021, directed to rinse mouth with water after breathing in the medications, to spit out the water and not to swallow the water. The licensee's Inhaler policy dated August 1, 2021, indicated inhaler medications must be administered according to the prescriber's orders and verified with the manufacturer's requirements per instructions and to provide resident the opportunity to rinse out mouth.	01760		

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01760	Continued From page 95 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to 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;	01790		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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01790	Continued From page 96 (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed 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 the registered nurse (RN) developed a written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to provide complete documentation of the medications sent with the resident for one of one resident (R1) who had an unplanned time away. This had the potential to affect all 20 residents	01790		

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01790	Continued From page 97 who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 8, 2022, at approximately 9:25 a.m., licensed practical nurse (LPN)-A and the regional director of operations (RDO)-G confirmed the licensee provided medication management services to residents at the facility. UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP The licensee failed to develop and implement a written procedure for the ULP providing medications for residents having unplanned times away. On February 10, 2022, at approximately 10:15 a.m., LPN-A stated the ULP prepared medications to send with residents for unplanned time away. LPN-A stated she was unaware if an RN developed a written procedure for the ULP to follow for unplanned time away and further stated she learned the procedure from the ULP. On February 10, 2022, at approximately 5:28 p.m., LPN-A confirmed the licensee did not develop a written procedure for unplanned time away.	01790		

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01790	Continued From page 98 DOCUMENTATION FOR UNPLANNED TIME AWAY R1's record lacked a list of R1's diagnoses. R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing. R1's record lacked signed prescriber orders. On February 8, 2022, at approximately 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's afternoon medication. ULP-D confirmed she would prepare and send medications with the residents for unplanned time away and confirmed there was no written procedure to follow. R1's medication administration record (MAR) dated February 1, through February 9, 2022, indicated R1's medications were "declined or skipped" February 3, through February 6, 2022, and referred to medication notes. R1's medication notes from February 3, 2022, through February 6, 2022, indicated R1's medications were "sent". R1's record lacked documentation of the medications provided to the resident or the resident's designated representative to include who received the medications, the person who provided the medications to the resident, the name and quantity of the medications provided, if any unused medications were returned, and a review by the RN to verify that the procedure was followed for the above noted times away from home.	01790		

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01790	Continued From page 99 On February 10, 2022, at approximately 5:04 p.m., LPN-A verified R1 had unplanned time away from February 3, 2022, through February 6, 2022. LPN-A further stated a ULP prepared R1's medications and sent the medications with R1 for her time away from home. LPN-A confirmed R1's record lacked documentation of medications sent, if any medications were returned, or if the RN verified the procedure was followed during R1's time away from home. The licensee's Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, for unplanned time away, the registered nurse (RN) was to develop written procedures for the unlicensed personnel, including any instruction or procedures regarding controlled substances that are prescribed for the resident. The procedure must address the following: -the type of container or containers to be used for the medications appropriate to the provider's medication system; -how the container or containers must be labeled; - the written information about the medications to be given to the resident or resident's representative; - how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information; -how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before	01790		

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01790	Continued From page 100 the medications are given to the resident or the resident's representative; -a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and -how the unlicensed staff must document in the resident's record any unused mediations that are returned to the provider, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders were obtained for one of two residents (R1) with records reviewed. 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	01820		

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01820	Continued From page 101 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 19, 2021. R1's record lacked a list of R1's diagnoses. R1's record lacked a service plan; however, R1's document titled Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing. R1's record lacked signed prescriber orders. On February 8, 2022, at 10:55 a.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's scheduled medications. R1's medication administration record (MAR), dated January 1, 2022, through February 9, 2022, indicated the following medications were administered: -Klonopin 0.5 milligrams (mg) twice daily for symptoms of seizures and panic disorder; -fluoxetine hcl 40 mg one capsule twice a day for depression, panic attacks, and obsessive-compulsive disorder; -acetaminophen 500 mg two tablets three times a day for pain management; -artificial tears 1.4 percent one drop to both eyes every four hours as needed. Self-administration; -furosemide (a diuretic) 20 mg one tablet daily; -hydrocodone-acetaminophen 5 mg/325 mg one table daily for moderate pain; -hydrochlorothiazide 12.5 mg one tablet every morning for high blood pressure;	01820		

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01820	Continued From page 102 -latanoprost one drop in each eye daily for glaucoma; -metoprolol succinate er 50 mg one tablet daily for high blood pressure; -prednisone 15 mg one tablet daily for pain; -pregabalin 75 mg one capsule daily for nerve pain; -Prozac 40 mg one tablet daily for depression; -Rifampin 300 mg one tablet twice a day to treat tuberculosis; -Topamax 200 mg one tablet daily for epilepsy; -Tylenol 500 mg two tablets three times a day for pain management-self administration; -Zofran 8 mg one tablet once per week before Vitamin-D is given on Thursday; -Zyrtec 10 mg one tablet daily to treat allergy symptoms; -vitamin b 12 injection 1000 mcg/ml one time per month; -vitamin d 1.25 mg one capsule once a week on Thursdays; and -Xarelto 15 mg one tablet daily for chronic atrial fibrillation. On February 10, 2022, at approximately 10:13 a.m., licensed practical nurse (LPN)-A confirmed R1 did not have signed prescriber orders in R1's record and confirmed the licensee was providing medication administration for R1. The licensee's Medication and Treatment Orders Policy dated August 1, 2021, indicated a current, written prescriber's orders must be obtained for any treatment or medication administration proved to the resident. The policy further indicated, an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment.	01820		

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01820	Continued From page 103 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to renew prescriptions at least every 12 months for one of two residents (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked an annual renewal of prescriber orders for medications. R2's diagnoses included dementia, anxiety, major depressive disorder and palliative care. R2's record lacked a Service Plan; however, included document titled Planned Services, dated	01830		

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01830	Continued From page 104 August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration. R2's Individual Medication Management Plan dated February 8, 2022, indicated R2 received medication administration due to being legally blind and needing supervision during medication administration due to swallowing difficulties. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E seated beside R2's wheeled support chair at the table in the dining room, assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. R2's Med (Medication) Admin (Administration) Summary, dated February 1, 2022, through February 8, 2022, included the following medications: -acetaminophen (pain reliever) 325 mg (milligrams) two tablets by mouth (po) four times daily; -ariprazole (treat agitation) 10 mg, take one half tab po twice daily; -aspirin (treat pain) 325 mg one tablet po daily; -gabapentin (prevent seizures or nerve pain) 300 mg one capsule po three times daily; -hydromorphone (treat moderate to severe pain) 2 mg solutab, take one half of 4 mg tab po four times daily; -pantoprazole (treat acid reflux) 40 mg po once daily; -polyethylene glyco 3350 powder (treat constipation) 17 grams mixed in liquid po once daily; -Senna-S (treat constipation) 8.6-50 mg one tablet po twice daily;	01830		

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01830	Continued From page 105 -duloxetine (treat depression) DR (delayed release) 30 mg, take three capsules po once daily; -hydrophilic ointment (moisturizer) apply to coccyx area daily; melatonin (for sleep) 3 mg take two tablets po at bedtime; -tamsulosin (treat urination difficulty) 0.4 mg one capsule po at bedtime; and -trazodone (treat depression) 100 mg tablet po at bedtime. R2's most current prescriber orders, dated January 23, 2021, included all of the above medications; however, was sixteen (16) days past the annual renew date requirement. On February 11, 2022, at approximately 10:36 a.m., licensed practical nurse (LPN)-A confirmed R2's prescriber orders had not been updated at least annually as required. The licensee's Medication & Treatment Orders-Renewal policy, dated August 1, 2021, indicated residents who receive medication management services would have a current physician prescribed medication order on record. The policy further included medication orders must be renewed at least every 12 months, or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 106 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 temperatures for two of two medication refrigerators (A, B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 8, 2022, at approximately 9:25 a.m., licensed practical nurse (LPN)-A and the regional director of operations (RDO)-G indicated the licensee provided medication management services to the licensee's residents, including storage of medication. FIRST FLOOR MEDICATION REFRIGERATOR A On February 8, 2022, at approximately 11:52 a.m., during initial tour of medication room on the first floor, LPN-A stated the night shift staff were	01880		

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01880	Continued From page 107	01880		

responsible for recording daily medication refrigerator temperatures. LPN-A confirmed refrigerator A temperatures logs were not being recorded daily. The surveyor requested a history of recorded temperature logs.

On February 11, 2022, at approximately 10:42 a.m., the surveyor observed the medication refrigerator A on the first floor with administrative assistant (AA)-K to verify contents of the refrigerator. AA-K confirmed the current refrigerator temperature to be 39 degrees Fahrenheit (F) and confirmed the refrigerator lacked daily monitoring of temperatures.

Refrigerator A contained the following contents:
-one opened vial of Moderna COVID-19 vaccine;
-one unopened vial of Moderna COVID-19 vaccine;
-five unopened Victoza pen (antidiabetic medication in a multiple dose pen shaped injector device used for insulin administration);
-eight unopened Novolog (short acting insulin) pens;
-one unopened Lantus Solostar (long acting insulin) pen; and
-five unopened Tresibal Flex Touch (ultralong-acting insulin) pens.

SECOND FLOOR MEDICATION REFRIGERATOR B

On February 8, 2022, at approximately 11:28 a.m., the surveyor observed the refrigerator B temperature log on sheet of paper which had one recorded temperature dated incorrectly of March 4, 2022, at 4:11 a.m., of 31 degrees F. Unlicensed personnel (ULP)-B stated refrigerator temperatures were recorded on the night shift and was unsure where the previously recorded

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01880	Continued From page 108 temperature logs were kept. On February 9, 2022, at approximately 7:47 a.m., the surveyor observed refrigerator B with ULP-F. ULP-F verified the last temperature recorded was dated for March 4, 2022, at 4:11 a.m., of 31 degrees F. ULP-F checked for a thermometer inside the refrigerator and found a digital thermometer with a reading of 41 degrees F. On February 9, 2022, at 11:28 a.m., the surveyor made a second request to LPN-A for refrigerator A and B's recorded temperature log history. On February 10, 2022, at approximately 10:30 a.m., LPN-A provided refrigerator A and B temperature logs from year 2021. The refrigerator temperature logs indicated the appropriate temperature range for medications were between 36-46 degrees F. The temperature logs indicated the following: -February 2021 log contained seven of a possible 28 temperatures recorded and four of the temperatures were above range for unknown refrigerator; -May 2021 log contained 28 of a possible 31 temperatures recorded and one temperature was below range for refrigerator A; -June 2021 log contained 28 of a possible 30 temperatures recorded which all were within range for unknown refrigerator; -July 2021 log contained 26 of a possible 31 temperatures recorded which all were within for unknown refrigerator; -September 2021 contained 29 of a possible 30 temperatures recorded and 12 temperatures were above range for unknown refrigerator; -October 2021 contained 26 of a possible 31 temperatures recorded and seven temperatures were above range for unknown refrigerator;	01880		

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01880	Continued From page 109 -November 2021 contained 19 of a possible 30 temperatures recorded and seven temperatures were above range, and three were below range for refrigerator A; and -December 2021 contained 22 of a possible 31 temperatures recorded and 11 temperatures were below range for unknown refrigerator. LPN-A also included an untitled white sheet of copy paper which included recorded dates, times, and temperatures from an unknown source. LPN-A stated she found this sheet with the 2021 temperature logs but could not identify where temperatures were recorded from. The white sheet of paper indicated the following: -January 7, 2022, at 3:00 a.m., of 33 degrees F; -January 10, 2022, at 4:00 a.m., of 34 degrees F; and -January 7, 2022, at 12:00 a.m., of 34 degrees F. On February 11, 2022, at approximately 7:59 a.m., the surveyor observed refrigerator B's internal digital thermometer indicated 37 degrees F. Refrigerator B temperature log remained unchanged with the only date recorded of date of March 4, 2022 at 4:11 a.m. On February 11, 2022, at approximately 9:22 a.m., LPN-A verified refrigerator A and B temperatures were not being monitored and recorded daily as required, and further stated she could not find refrigerator temperature logs for refrigerators A and B for the current 2022 year. On February 11, 2022, at approximately 10:51 a.m., the surveyor observed refrigerator B with ULP-D and confirmed refrigerator B contained the following contents: -nine Lantus Solostar insulin pens; -12 Novolog Flex insulin pens; and	01880		

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01880	Continued From page 110 -25 Gentle Bladder (sterile water used to irrigate a urinary catheter) 0.4 milligram (mg) per milliliter (ml) prefilled syringes. The manufacturer's instructions for Moderna dated January 31, 2022, indicated vials may be stored in the refrigerator between 36-46 degrees Fahrenheit (F) for up to 30 days prior to first use; and vials should be discarded 12 hours after the first puncture. Moderna vials stored between 46 to 77 degrees F for a total of 24 hours; and vials should be discarded 12 hours after first puncture. The manufacturer's instructions for Victoza revised September 2020, indicated before opening store Victoza pens in the refrigerator 36-46 degrees F. Do not allow Victoza to freeze. The manufacturer's instructions for Lantus insulin pens revised November 2018, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog dated April 2015, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Novolog to freeze. The manufacturer's instructions for Tresibal revised September 2015, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow to freeze. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).	01880		

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01880	Continued From page 111 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 review, the licensee failed to date time-sensitive medications with an opened-on date for five of six residents (R4, R5, R6, R7, R8 and R9). In addition, the licensee failed to ensure medication containers had the original prescription label for two of six residents (R4 and R6) with records reviewed. 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). Findings include:	01890		

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01890	Continued From page 112 On February 8, 2022, at approximately 11:14 a.m., the surveyor conducted an observation of the second-floor medication cart with unlicensed personnel (ULP)-B. The medication cart contained the following: -R5's Ipratropium Bromide nasal spray lacked the date the nasal spray was opened and would expire; -R4's Wixela Inhub 250-50 micrograms (mcg) inhaler lacked a prescription label and lacked the date the inhaler was opened and would expire; -R4's Novolog Flex insulin pen lacked a prescription label, the date the insulin pen was opened and when the insulin pen would expire; -R9 who was no longer a resident at the facility had a Ventolin HFA inhaler which lacked the date the inhaler was opened and would expire; and -Deep Sea nasal spray which lacked a prescription label. On February 8, 2022, at approximately 11:28 a.m., ULP-B confirmed medications should have original labels with the opened date and date of expiration. On February 8, 2022, at approximately 12:12 p.m., the surveyor observed the first-floor medication cart with ULP-J. The medication cart contained the following: -R6's Albuterol Sulfate inhaler lacked a dated the inhaler was opened and when the inhaler would expire; -R6's Symbicort inhaler lacked a label, the date the inhaler was opened and when it would expire. -R7's calcitonin salmon nasal spray lacked the date the nasal spray was opened and would expire. -R8's Tresibal Flex insulin pen lacked the date the insulin was opened and would expire.	01890		

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01890	Continued From page 113 On February 8, 2021, at approximately 12:14 p.m., licensed practical nurse (LPN)-A confirmed all medications should have prescription labels, a date when the medication was opened and when they would expire. The manufacturer's instructions for Ipratropium Bromide dated November 14, 2002, indicated use up to 35 days after opening. The manufacturer's instructions for Wixela Inhub inhaler revised January 2019, directed to discard the inhaler 30 days after removal from foil pouch. The manufacturer's instructions for Novolog Flex pen dated June 2021, directed to discard the pen 28 days after opened. The manufacturer's instructions for Ventolin/Albuterol inhalers dated January 2022, directed to discard the inhaler 12 months after removal from the foil pouch. The manufacturer's instructions for Symbicort inhalers dated July 26, 2021, directed to discard the inhaler three months after removal from the foil pouch. The manufacturer's instructions for calcitonin salmon nasal spray dated September 2017, directed to discard 35 days after opening. The manufacturer's instructions for Tresibal Flex insulin revised September 2015, directed to discard the pen 56 days after it had been opened. The licensee's Medications-Prescribed, Not Prescribed & OTC, dated August 1, 2021, indicated the licensee must verify the medications are up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01910	Continued From page 114	01910		
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 record the disposition of the medications as required for one of one resident (R3) upon discharge, with records reviewed. 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	01910		

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01910	Continued From page 115 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked documentation of medication disposition upon R3's discharge from the facility. R3 was discharged on October 30, 2021, after receiving services for diagnoses including elevated blood pressure and urinary incontinence. R3's discharge summary, printed February 8, 2022, indicated R3 received services including medication management, assistance with activities of daily living, and supervision for safety due to mental health issues and decline in memory. The discharge summary indicated medications were given in the morning and evening for behavior management. R3's discharge summary also included a Med (medication) Disposition Summary which was blank. On February 11, 2022, at approximately 9:49 a.m., licensed practical nurse (LPN)-A verified the medication disposition form was blank and the record lacked documentation of the disposition of R3's medications upon discharge. The licensee's Medication Disposal policy, dated August 1, 2021, indicated upon disposition, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided.	01910		

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01910	Continued From page 116 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940		

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01940	Continued From page 117 by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with records reviewed. 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). Findings include: During the entrance conference on February 8, 2021, at approximately 9:38 a.m., licensed practical nurse (LPN)-A and regional director of operations (RDO)-G stated the licensee provided treatment management services to residents, including blood glucose checks, oxygen assistance, and compression stockings. R2's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to	01940		

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01940	Continued From page 118 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 had a contract signed by R2's representative on August 23, 2021. R2's record lacked a Service Plan; however, included Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance, medication administration and oxygen assistance. R2's prescriber orders dated January 23, 2021, included oxygen inhalation for shortness of breath, as needed, at 1-4 liters per nasal cannula. On February 9, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E seated beside R2's wheeled support chair at the table in the dining room, assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth. R2 had nasal cannula in place with portable oxygen on the back of her chair. On February 11, 2022, at approximately 11:00 a.m., LPN-A verified a treatment management plan with the required content had not been developed for R2. The licensee's Treatment & Therapy Management Plan policy, dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident	01940		

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01940	Continued From page 119 which must contain at least the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; - any resident-specific requirements relating to documentation of treatment and therapy received; - verification that all treatment and therapy was administered as prescribed; and - monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=F	144G.91 Subd. 4 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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for six of six residents (R15, R2, R13, R1, R14, R12)	02310		

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02310	Continued From page 120 with bedrails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R15 On February 10, 2022, at approximately 12:47 p.m., surveyors observed licensed practical nurse (LPN)-A measure R15's single bedrail on the outside of his bed, not affixed to the bed, and slid under the mattress. R15 stated his mother bought the bedrail and he didn't want it removed. The openings between the bars for zone 1, measured 4 1/4 inches. The measurements between the mattress and the bedrail for zone 3, measured 4 3/4 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 3 3/8 inches. R15 had diagnoses including seizure disorder. R15's medical record included Resident Profile, dated October 29, 2021, indicated R15's services included behavior management, bathing assistance, blood glucose monitoring, housekeeping and laundry. R15's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails.	02310		

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02310	Continued From page 121 R2 On February 10, 2022, at approximately 12:48 p.m., surveyors observed LPN-A measure R2's assistive device, referred to as "Halo." LPN-A stated hospice had provided the device, which was in the shape of a circle on the right side of R2's bed. The measurements between the mattress and the device for zone 3, measured 2 1/2 inches. R2 had diagnoses including dementia, anxiety disorder, major depressive disorder and palliative care. R2's record lacked a Service Plan; however, included Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, well being checks, bathing assistance, activities of daily living, meal assistance, medication administration and oxygen assistance. R2's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R13 On February 10, 2022, at approximately 12:51 p.m., surveyors observed LPN-A measure R13's assistive device, which LPN-A stated was new and referred to as a grab bar, was round in shape, slid under the mattress, and had a strap to secure it under the bedframe. The device was on the right side of the bed. The opening in the center of the device measured 4 1/2 inches for zone 1, and there was no space between the mattress and the device for zone 3. R13's diagnoses included bipolar disorder, concussion, edema of cervical spinal cord and	02310		

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02310	Continued From page 122 depression. R13's Resident Profile, dated December 20, 2021, indicated R13's services included behavior management, bathing assistance, dressing, blood glucose monitoring, well checks, housekeeping and laundry. R13's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R1 On February 10, 2022, at approximately 12:54 p.m., surveyors observed LPN-A measure R1's bilateral bedrails. The bedrail on the right side of the bed was in the down position and was loose, the left side was up. The openings between the bars for zone 1, measured 3 3/4 inches. The measurements between the mattress and the bedrail for zone 3, measured 2 1/2 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 4 3/4 inches. LPN-A was able to tighten the bedrail on the right side of the bed, and stated R1 doesn't usually have that bedrail up but uses it in the down position to pull herself up. R1's record lacked a list of R1's diagnoses. R1's record lacked a service plan; however, R1's Planned Services dated February 9, 2022, indicated R1 received services which included medication administration, housekeeping, laundry and assistance with bathing. R1's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails.	02310		

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WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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02310	Continued From page 123 R14 On February 10, 2022, at approximately 12:56 p.m., surveyors observed LPN-A measure R14's bilateral bedrails. The openings between the bars for zone 1, measured 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 1/2 inch. Both bedrails were loose and LPN-A was able to tighten them. R14 had diagnoses including multiple sclerosis, depression, cognitive dysfunction and muscle spasms. R14's Resident Profile, dated April 27, 2018, indicated R14 received services including exercise program, bathing assistance, behavior management, catheter care, dressing, grooming, medication reminders and meal assistance. R14's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R12 On February 10, 2022, at approximately 12:59 p.m., surveyors observed LPN-A measure R12's bilateral affixed bedrails. The openings between the bars for zone 1, measured 3 1/2 to 4 3/4 inches. The measurements between the mattress and the bedrail for zone 3, measured 1 1/2 inches. The measurements between the head of the bed and the mattress for zone 7, measured 2 inches. R12 had diagnoses including Parkinson's Disease, diabetes, memory loss and gait instability. R12's Resident Profile, dated July 15, 2019,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
02310	Continued From page 124 indicated R12 received services including behavior management, catheter care, dressing, mobility assistance, grooming, housekeeping and laundry. R12's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. On February 10, 2022, at approximately 1:10 p.m., regional director of operations (RDO)-G stated the licensee had received a citation in January 2022, from the Office of Health Facility Complaints for bedrail usage within the facility, and stated they removed all of the bedrails at that time. Later, each of the residents' physicians signed orders for the resident to have bedrails on their bed, they were put back on, had a bedrail assessment, and risk versus benefits were discussed with each resident. RDO-G stated she was unable to find the documentation of those assessments and written acknowledgements of the risk versus benefits conversation. The licensee's Side Rails policy, dated August 1, 2021, noted the RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rails, and verify the design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and	02310		

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	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
02310	Continued From page 125 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a dignified dining experience for one of one resident (R2) observed during dining. 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	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDWOOD ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

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02350	Continued From page 126	02350		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R2's diagnoses included dementia, anxiety, major depressive disorder and palliative care.

R2's record lacked a Service Plan; however, included Planned Services, dated August 18, 2021, which indicated R2 received assistance with repositioning, wellbeing checks, bathing assistance, activities of daily living, meal assistance and medication administration.

On February 9, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-E seated beside R2's wheeled support chair at the table in the dining room, assisting R2 with eating her breakfast, bringing spoonfuls of hot cereal to her mouth.

On February 9, 2022, at approximately 9:05 a.m., the surveyor observed ULP-E reach under the table to retrieve a cell phone, and was observed to be sending text messages, until she looked up, saw the surveyor and quickly placed the cell phone back under the table.

On February 9, 2022, at approximately 9:08 a.m., licensed practical nurse (LPN)-A stated staff were not allowed to use their cell phones, unless they were on break.

During an interview on February 9, 2022, at approximately 9:40 a.m., ULP-E stated she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	02/11/2022

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02350	Continued From page 127 texting to arrange transportation for her children and verified she should not be using her cell phone while assisting residents. A policy regarding dignity/respect of residents was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02350		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/08/22*
Time: 11:45:58
Report: 7930221025

Food and Beverage Establishment Inspection Report

Location:
Wildwood Assisted Living
1420 2nd Street North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0039135
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202022946
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

FLOOR CLEANER AND DAWN DISH SOAP WAS STORED ON TOP OF THE DISHWASHER AT TIME OF INSPECTION. STORE IN CHEMICAL AREA OR ON THE SHELF UNDER THE DISHWASHER.

Comply By: 02/09/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE A WATERPROOF THERMOMETER OR THERMO-LABELS TO MONITOR THE FINAL RINSE CYCLE OF THE DISHWASHER LIKE STATED ABOVE.

Comply By: 02/15/22

2-100 Supervision

2-102.12AMN

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

ANDREA SMITH HAS HER SERV SAFE CERTIFICATE BUT NOT A STATE CERTIFICATE. SEND ONE FULL TIME EMPLOYEE TO THE CLASS. ONCE THE TEST IS PASSED, SEND IN TEST RESULTS, $35 FEE & APPLICATION TO GET THE STATE CERTIFICATE WITHIN 6 MONTHS OF COURSE. APP EMAILED.

Comply By: 04/08/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

BIN OF CREAMY WHEAT HAD A CONDIMENT CUP STORED IN IT. REMOVE CONDIMENT CUP AND USE SCOOPS WITH HANDLES FOR DISPENSING.

Comply By: 02/09/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

STORE BOXES OF CHIPS AND OTHER FOODS UP OFF OF THE FLOOR IN THE STORAGE ROOM. FOOD ON THE FLOOR WAS DELIVERED 2/7/22.

Comply By: 02/09/22

4-200 Equipment Design and Construction

4-201.11AMN

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

THE FOLLOWING EQUIPMENT IS NOT COMMERCIAL: CHEF'S CHOICE MEAT SLICER, SUNBEAM STAND MIXER AND CROCKPOT. REMOVE FROM ESTABLISHMENT AND REPLACE WITH ANSI CERTIFIED EQUIPMENT.

Comply By: 03/08/22

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

PLASTIC LIDS AND OTHER SINGLE-SERVICE ITEMS WERE STORED ON THE FLOOR IN THE DRY STORAGE ROOM. SOME WERE DELIVERED IN NOVEMBER AND OTHERS WERE DELIVERED 2/7/22. ALL SINGLE-SERVICE ITEMS MUST BE STORED UP OFF OF THE FLOOR.

Comply By: 02/09/22

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

ALL SPOONS AND UTENSILS IN UPRIGHT CONTAINERS NEED TO BE STORED WITH THE HANDLE POINTING UP. AT TIME OF INSPECTION SPOONS AND UTENSILS WERE STORED WITH THE EATING SURFACE POINTING UP.

Type: Full
Date: *02/08/22*
Time: 11:45:58
Report: 7930221025
Wildwood Assisted Living

Food and Beverage Establishment Inspection Report

Comply By: 02/09/22

Surface and Equipment Sanitizers

Hot Water: = at 162.1 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET--PREP TABLE
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: TURKEY--LEFT UPRIGHT COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: STUFFING--RIGHT UPRIGHT COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	6

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 7930221025 of 02/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

Establishment Representative

Inspector ID #7930

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