

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

October 1, 2019

Administrator Reflections Assisted Living 300 Second Street SW Austin, MN 55912

Re: Project Number SL25944009

Dear Administrator:

On September 18, 2019, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on May 24, 2019; and follow-up survey completed on August 7, 2019. At this time these correction orders were found corrected and are listed on the attached State Form: *Revisit Report*.

If you have questions, contact Jeri Cummins at (218) 302-6193.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

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Health Regulation Division

Home Care & Assisted Living Program



cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care

Mower County Social Services

		STATE F	ORM: REV	ISIT REPORT				
PROVIDER / SUPPLIER / IDENTIFICATION NUMBE H25944	A. Building	STRUCTION				Y2	DATE OF RE	
NAME OF FACILITY REFLECTIONS ASSIST	11 9			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SECOND STREET SW AUSTIN, MN 55912				
This report is completed corrective action was actidentification prefix code form).	complished. Each defi	ciency should b	oe fully identif	ied using either the r	egulation o	r LSC provision	number and	the
ITEM	DATE	ITEM		DATE	ITEM		DA	TE
Y4	Y5	Y4		Y5	Y4		١	/ 5
ID Prefix 00560	Correction	ID Prefix 009	05	Correction	ID Prefix	00920	Cor	rection
Reg. # 144A.474, Subd	. 8 Completed	Reg. #	A.4792, Subd.	2 Completed	Reg. #	144A.4792, Subd	l. 5 Cor	mpleted
LSC	09/18/2019	LSC		09/18/2019	LSC			18/2019
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Cor	rection
Reg. #	Completed	Reg. #		Completed	Reg. #		Cor	mpleted
LSC		LSC			LSC			
ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Cor	rection
Reg. #	Completed	Reg. #		Completed	Reg. #		Cor	mpleted
LSC		LSC			LSC			
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Reg. #	Completed	Reg. #		Completed	Reg. #		Cor	mpleted
LSC		LSC			LSC			
REVIEWED BY STATE	REVIEWED BY	DATE: 10/1/19	SIGNATU	RE OF SURVEYOR: 3°	1217		DATE: 9/18/1	9



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2019

Administrator Reflections Assisted Living 300 Second Street SW Austin, MN 55912

RE: Project Number SL25944009

Dear Administrator:

On August 7, 2019, the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on May 24, 2019. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the May 24, 2019 survey.

In accordance with Minn. Stat. § 144A.474, subd. 11, state licensing orders issued pursuant to the last survey completed on May 24, 2019, found not corrected at the time of the August 7, 2019 follow-up survey and subject to penalty assessment are as follows:

0905-Provision Of Medication Mgt Services-Minn. Stat. § 144A.4792, subd. 2 - \$500.00 0920-Individualized Medication Mgt Plan-Minn. Stat. § 144A.4792, subd. 5 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on August 7, 2019 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is \$1,000**. You will be invoiced within 15 days of the receipt of this notice.

Also, at the time of this follow-up survey completed on August 7, 2019, we identified the following violation(s):

0560-Correction Orders-Minn. Stat. § 144A.474, subd. 8

The details of the violation(s) noted at the time of this re-inspection 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.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144A.474, subd. 8(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, 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 § 144A.475 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, subd. 12, 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. You are required to send your written request to the following:

Renae Dressel, Health Program Rep. Sr. Home Care Assisted Living Program Minnesota Department of Health P.O. Box 3879 85 East Seventh Place St. Paul, MN 55101

We urge you to review these orders carefully. If you have questions, please contact Jeri Cummins at (218) 302-6139.

Reflections Assisted Living September 3, 2019 Page 2

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 agency's Governing Body.

Sincerely,

PAULA M. BASTIAN Senior Health Program Representative Health Regulation Division

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Home Care & Assisted Living Program



cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care Mower County Social Services

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
H25944 _{Y1}	B. Wing	Y2	8/7/2019	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
REFLECTIONS ASSISTED LIV	ING	300 SECOND STREET SW		
		AUSTIN, MN 55912		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. # LSC	00380 144A.441		Correction Completed 08/07/2019	ID Prefix Reg. # LSC		72, Subd. 3	Correction Completed 08/07/2019	ID Prefix Reg. # LSC	00825 144A.4791, Subd	. 1	Correction Completed 08/07/2019
ID Prefix Reg. # LSC	00835 144A.4791, Sub	od. 3	Correction Completed 08/07/2019	ID Prefix Reg. # LSC		792, Subd. 10(a)	Correction Completed 08/07/2019	ID Prefix Reg. # LSC	00950 144A.4792, Subd	. 10(b)	Correction Completed 08/07/2019
ID Prefix Reg. # LSC	01010 144A.4792, Sub	od. 22	Correction Completed 08/07/2019	ID Prefix Reg. # LSC		.795, Subd. 7(b)	Correction Completed 08/07/2019	ID Prefix Reg. # LSC	01150 144A.4795, Subd	. 7(c)	Correction Completed 08/07/2019
ID Prefix Reg. # LSC	01170 144A.4796, Sub	od. 2	Correction Completed 08/07/2019	ID Prefix Reg. # LSC		797, Subd. 3	Correction Completed 08/07/2019	ID Prefix Reg. # LSC	01245 144A.4798, Subd	. 1	Correction Completed 08/07/2019
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWS CMS RO	ED BY	REVIEW (INITIALS REVIEW (INITIALS	ED BY	DATE: 9/3 DATE		SIGNATURE OF TITLE			A SUMMARY OF	DATE: 8	3/7/19
5/24/201	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO										

Page 1 of 1 EVENT ID: 7GDO12

PRINTED: 09/03/2019 FORM APPROVED

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		H25944			R 08/07/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	00/07/2013
REFLEC	TIONS ASSISTED LIV	'ING 300 SECO AUSTIN, N	ND STREET IN 55912	r SW	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{0 000}	Initial Comments		{0 000}		
	In accordance with 144A.43 to 144A.45 been issued pursual Determination of which corrected requires requirements provisindicated below. Which contains several ite of the items will be compliance. INITIAL COMMENT #SL25944009 On August 5, 6, and Department's staff above Comprehens follow-up on orders completed on May survey, there were services. As a resulting to 144A.45 and 144A.45 to 144A.45	Minnesota Statutes, section 82, this correction order(s) has ant to a survey. The ther a violation has been compliance with all ded at the Statute number hen Minnesota Statute ems, failure to comply with any considered lack of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag number appears in the far left column entity Prefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficient column. This column also includes findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the survindings is the Time Period for Column STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.	oftware. I to e Care per cled "ID aber and e Statute ies" s the ne state This as eyors' rrection. DING CH TO THIS O DN FOR
				The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144A subd.11 (b) (1) (2).	scope
0 560 SS=F	144A.474, Subd. 8	Correction Orders	0 560		

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

TITLE (X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H25944	B. WING		08/0	₹ 17/2019
	PROVIDER OR SUPPLIER	300 SECO	ND STREET	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 560	This MN Requirements by: Based on interview review, the licensee corrections orders of completed on May and the process of the second of the s	ent is not met as evidenced defailed to comply with from a previous survey 24, 2019. def in a level two violation (a tharm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when desive or represent a systemic cted or has potential to affect at approximately 9:30 a.m., ing specialist) reported steps correct all orders from the mpleted on May 24, 2019. , 2019, a review of the n order documentation, and d evidence the licensee had ensing orders from the noted above. at approximately 11:00 a.m., ered nurse), and employee B indings.	0 560			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		H25944	B. WING		08/0	7/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECO AUSTIN, M	ND STREET IN 55912	T SW		
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{0 905}	Continued From pa	ge 2	{0 905}			
{0 905} SS=F	144A.4792, Subd. 2 Services	2 Provision of Medication Mgt	{0 905}			
	services. (a) For earmedication manager comprehensive hor providing medication have a registered in professional, or aut section 151.37 condetermine what me services will be provided. The conducted face-to-tassessment must in review of all medicataking. The review indications for medications for medications to addression of medications of medications of medications of medications of medications of medications. The review indications for medications to addression of medications of medications of medications. This MN Requirements or improper dispositions.	me care provider shall, prior to on management services, burse, licensed health chorized prescriber under duct an assessment ot dication management vided and how the services his assessment must be face with the client. The include an identification and ations the client is known to be and identification must include ications, side effects, allergic or adverse reactions,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		H25944	B. WING		08/ 0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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{0 905}	assessment to incluone of one client (# This practice result violation that did no safety but had the policient's health or sa cause serious injury was issued at a wide problems are pervafailure that has affer a large portion or a include: Client #2's diagnos limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension. The order of the diagnost limited to, schizoaff hypertension, schizoaff hypertension, side of allergic or adverse address these issued on August 7, 2019, employee A (register medication assession was the same form employee was unaverified client #2 ar lacked the above results and the diagnost limited to the diagnost li	medication management ude all the required content for 12) with records reviewed. ed in a level two violation (a set harm a client's health or cotential to have harmed a fety, but was not likely to by, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect all of the clients). The findings the client's "Service Plan," dated cated the client received ement services. Ition Assessment" dated June review of all medications the code indications for effects, contraindications, reactions, and actions to es. It approximately 11:00 a.m., ered nurse), indicated the ment form used for client #2 used for all clients. The ware of the requirement, and and all other client records	{0 905}			
		assessment for clients				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		H25944	B. WING			R 07/2019
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{0 905}	Continued From pa	ge 4	{0 905}			
	medications; however, none were provided.					
	No further informati	on was provided.				
{0 920} SS=F	144A.4792, Subd. Mgt Plan	5 Individualized Medication	{0 920}			
	plan. (a) For each of management service care provider must service plan a writte medication manage provided to the clie provider must deveindividualized medicach	ement services that will be nt. The lop and maintain a current cation management record for client's assessment that must				
	management service (2) a description of on the client's need diversion, and considerations; (3) documentation of relating to the admit (4) identification of monitoring medication refills and (5) identification of tasks that may be of personnel; (6) procedures for some or appropriate when	cribing the medication ces that will be provided; storage of medications based is and preferences, risk of sistent with the manufacturer's of specific client instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management delegated to unlicensed staff notifying a registered e licensed health professional ith medication management				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	
		H25944	B. WING		08/0	? 7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
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	documenting medic verifications that all medications prescribed, and mo prevent possible complications or ad (b) The medication	fic requirements relating to cation administration, are administered as nitoring of medication use to everse reactions. management record must be d when there are any				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication management plans included all required content for one of one client (#2) with records reviewed.					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a of harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when a sive or represent a systemic cted or has potential to affect II of the clients). The findings				
	limited to, schizoaff hypertension. The	es included, but were not ective disorder, and client's "Service Plan," dated cated the client received ement services.				
		lacked a medication based on the medication				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
7.1.12 . 2.1			A. BUILDING:			
		H25944	B. WING		08/0	₹ 97/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	/IN(÷	OND STREET VIN 55912	r sw		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 920}	assessment that in medications the clie the time of the asse for medications, sid allergic or adverse address these issue On August 7, 2019, employee A (registe noted findings. The and all other client required content. A request was made	cluded a review of all ent was known to be taking at essment to include indications de effects, contraindications, reactions, and actions to es. at approximately 11:00 a.m., ered nurse), verified the above employee verified client #2 records lacked the above de to review the licensee medication management plan; re provided.	{0 920}			

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Protecting, Maintaining and Improving the Health of All Minnesotans

Email: priscillagcmi@charter.net; GTCORCORAN@CHARTER.NET

June 20, 2019

Mr. Gary Corcoran, Administrator Reflections Assisted Living 300 Second Street Sw Austin, MN 55912

Re: Enclosed State Licensing Orders - Project Number SL25944010

Dear Mr. Corcoran:

A survey of the Home Care Provider named above was completed on May 24, 2019 for the purpose of assessing compliance with State licensing regulations. At the time of survey, staff from the Minnesota Department of Health noted one or more violations of these regulations that are issued in accordance with Minn. Stat. 144A.43 to 144A.484. If, upon follow-up, it is found that the correction order(s) cited herein are not corrected, a fine for each order not corrected may be assessed in accordance with a schedule of fines described in Minn. Stat. 144A.474, subd. 11.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Statutes for Home Care 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 that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

DOCUMENTATION OF ACTION TO COMPLY

According to Minn. Stat. 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed. The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date. The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation

Reflections Assisted Living June 20, 2019 Page 2

received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health. Homecare@state.mn.us; or, if you prefer you can mail it to:

> Home Care Correction Order Reconsideration Process Minnesota Department of Health/Health Regulation Division P.O. Box 3879

85 East 7th Place, Suite 220 St. Paul, Minnesota 55101

We urge you to review these orders carefully. If you have questions, contact Jeri Cummins at (218) 302-6193.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative **Health Regulation Division**

Lawla Mhastian

Home Care & Assisted Living Program





cc:









Enclosure

Cheryl Hennen, Office of the Ombudsman for Long Term Care

Mower County Social Services

PRINTED: 06/20/2019 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPL	
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.2	00
REFLEC	TIONS ASSISTED LIV	VING 300 SECO AUSTIN, N	ND STREET	rsw		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	In accordance with 144A.43 to 144A.4 been issued pursual Determination of w corrected requires requirements provindicated below. W contains several ite of the items will be compliance. INITIAL COMMENT SL25944009 On May 21, 22, 23, this Department's sand the following contains and the service of the items will be compliance.	Minnesota Statutes, section 82, this correction order(s) has ant to a survey. hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute ems, failure to comply with any considered lack of TS: and 24, 2019, a surveyor of staff, visited the above provider orrection orders are issued. At vey, there were five clients that vices under the		Minnesota Department of Health documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota State Statutes for Homeroviders. The assigned tag numbers appears in the far left column ention Prefix Tag." The state Statute numbers to the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficient column. This column also include findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the survifindings is the Time Period for Content of the Fourth Column which states, "Provider's Plan Of Correction." This applies federal Deficiencies only will appear on Each Page. There is no requirement is used tracking purposes and reflects the and level issued pursuant to 1444 subd.11 (b) (1) (2).	oftware. It to ne Care ber tled "ID nber and e Statute cies" s the he state 'This as reyors' rrection. DING ICH F TO . THIS TO ON FOR TATE ed for e scope	
0 380 SS=C	144A.441 Assisted Addendum	Living Bill of Rights	0 380	Subu. 11 (b) (1) (2).		

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

(X6) DATE TITLE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H25944	B. WING		05/2	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECC AUSTIN, I	ND STREET NN 55912	- SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 380	Continued From pa	ge 1	0 380			
	144A.441 ASSISTED LIVING BILL OF RIGHTS ADDENDUM.					
	Assisted living clier 144G.01, subdivision the home care bill of rig 144A.44, except the provided to these clients must in place of the provided to these clients must in place of the provided to the provided in place of the provided to the provided in the right to rechanges in services and days' advance notic service by a provided (i) the recipient of signified in the employment care provider and the care services, or creates environment for the care services; (ii) an emergency for significant change in resulted in service service provider agents.	ats, as defined in section on 3, shall be provided with a shall be provided as a shall be provided as a shall be provided as a shall be a s				
	(iii) the provider has	s not received payment for at least ten days' advance				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. BOILDING.			
		H25944	B. WING		05/2	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECC AUSTIN, I	ND STREET MN 55912	T SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 380	Continued From pa	ige 2	0 380			
	of the termination of a service shall be provided."					
	by: Based on observat review, the licenses client and/or clients home care bill of rig for a 30 day advan- services for with re This practice result violation that has not a minimal impact of health and safety), widespread scope or represent a syste or has the potential of the clients). The Client #1's record la clients' representat current home care day advance notice service by a provid. On May 22, 23, and periodically observed.	ed in a level one violation (a o potential to cause more than in the client and does not affect and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all findings include: acked evidence the clients or ives had been provided the bill of rights to include the 30 e of the termination of a				
	employee B (housing of the "Minnesota Fated January 2014 their clients on admillacked the requirem	at approximately 12:30 p.m., ng specialist) provided a copy Home Care Bill of Rights" 4, the licensee provided to nission. The bill of rights nent of 30 days advance ation of a service by the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED	
		H25944	<u> </u>	NATATE TID CODE	05/2	4/2019
	PROVIDER OR SUPPLIER	300 SECO)ND STREET	STATE, ZIP CODE SW		
REFLEC	TIONS ASSISTED LIV	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 380	Continued From pa	ge 3	0 380			
	provider.					
	On May 23, 2019, at approximately 8:35 a.m., employee B verified client #1 and all other clients had not received the current home care bill of rights; to include, the required 30 day advance notice of the termination of a service by a provider.					
	the home care bill of	e to review policies related to of rights as required for its; however, none were				
	No further informat	ion was provided.				
	TIME PERIOD FOR Twenty-One (21) da					
0 475 SS=F	144A.472, Subd. 3	License Renewal	0 475			
	in section 144A.475 for	enewal. (a) Except as provided 5, a license may be renewed at if the licensee satisfies the				
		ication for renewal in the the commissioner at least 30 f the license;				
	(2) submits the rene specified in subdivi	ewal fee in the amount sion 7;				
	(3) has provided ho past 12 months;	ome care services within the				
	(4) complies with se	ections 144A.43 to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
	NAME OF PROVIDER OR SUPPLIER REFLECTIONS ASSISTED LIVING AUSTIN,			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 475	144A.4798; (5) provides informathe applicant meets licensure, including items required (6) provides verificated subdivision 1 are concessary by the concessa	ation sufficient to show that at the requirements of uired under subdivision 1; ation that all policies under urrent; and the remark of the requirements of the	0 475			
	by: Based on interview licensee failed to do required comprehe procedures upon on Comprehensive lice. This practice result violation that did not safety but had the polient's health or sa cause serious injury was issued at a wide problems are pervafailure that has affer	and document review, the evelop and implement the nsive home care policies and onversion to the ense on May 8, 2014. ed in a level two violation (a of harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/24/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	
REFLEC	TIONS ASSISTED LIV	/ING	ND STREET	rsw		
		AUSTIN, I	MN 55912			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 475	Continued From page 5		0 475			
	Comprehensive lice procedures were re (housing specialist) that were provided to, state home care licensee lacked pol conducting initial day ongoing evaluation client's needs by a appropriate license including how chan are identified, manastaff and other hea appropriate; supervision by the performing delegation contentation, training	equested from employee B). The policies and procedures included, but were not limited e class F statutes. The licies regarding the following: five day assessments, and 90 ations and assessments of the registered nurse (RN) or and health professional, ages in the client's conditions aged, and communicated to lith care providers, as RN of unlicensed personnel ed home care tasks; and g, and competency e care staff, and a process for				
	employee B verified	at approximately 8:35 a.m., d the above noted findings.				
	No further informat	ion was provided.				
	TIME PERIOD FOR Twenty-One (21) date					
0 825 SS=A	·	1 HBOR Notification to Client	0 825			
	notification to client shall	ne care bill of rights; t. (a) The home care provider				
	written notice of the before	r the client's representative a e rights under section 144A.44				
	the initiation of serv	vices to that client. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECC AUSTIN, I	OND STREET VIN 55912	r SW		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 825	provider shall make provide notice of the rights to the clie representative in a representative can understand. (b) In addition to the rights in section 14 notice shall also contain the describing how to forfices. "If you have a comperson providing you may call, write, or we facility Complaints Health. You may also contain for Long-Term Care for Mental Health a Disabilities." The statement shounumber, Web site a	e all reasonable efforts to ent or the client's language the client or client's e text of the home care bill of 4A.44, subdivision 1, the ne following statement ile a complaint with these claint about the provider or the our home care services, you risit the Office of Health , Minnesota Department of ect the Office of Ombudsman e or the Office of Ombudsman nd Developmental uld include the telephone	0 825			
	number, Web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	ING 300 SECC AUSTIN, I	OND STREET VIN 55912	T SW		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 825	a statement that the retaliate because of a comp (c) The home care acknowledgment of home care bill of rights or acknowledgment may be obtained from representative. Ack be retained in the client. This MN Requirement by: Based on observation review, the licensed written acknowledghome care bill of right (#2) upon conversion license as required. This practice resultativiolation that has not a minimal impact of health or safety), as scope (when one of are affected or one are involved or the occasionally). The first practice is a compared to the occasionally.	directed. It must also include home care provider will not laint. provider shall obtain written the client's receipt of the shall document why an annot be obtained. The om the client or the client's mowledgment of receipt shall of the receipt shall of the receipt of the ghts for one of three clients on to the comprehensive with records reviewed. The comprehensive with record receipt of the comprehensive with records reviewed. The comprehensive with records reviewed. The client and does not affect the comprehensive of the client and does not affect the comprehensive or a limited number of clients or a limited number of staff situation has occurred only findings include:	0 825			
	Client #2 was admi	tted for services on February				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/24/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	/IN(÷	OND STREET VIN 55912	· sw		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 825	16, 2013. The client indicate the client are representative were current Minnesotal January, 2014, upon comprehensive lice record lacked evide acknowledgment h. On May 22, 23, and periodically observatives from employersonnel). On May 24, 2019, a employee B (housing above noted finding A request was made the home care bill of	at's record lacked evidence to and/or the client's e provided a copy of the home care bill of rights dated on conversion to the ense. In addition, the client's ence as to why the written ad not be obtained. If 24, 2019, client #2 was ed to receive home care loyee D (unlicensed at approximately 11:30 a.m., and specialist) verified the g. If to review policies related to of rights as required for ats; however, none were	0 825			
0 835 SS=C		3 Statement of Home Care	0 835			
	to the initiation of s must provide to the representative a wr identifies if the prov has a basic or com	t of home care services. Prior ervices, a home care provider e client or the client's ritten statement which vider prehensive home care es the provider is authorized to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
	REFLECTIONS ASSISTED LIVING 300 SEC		DRESS, CITY, S DND STREET MN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 835	which services the the scope of the procare provider shall obtain from the clients that the statement or must of could not obtain the statement or must of could not obtain the statement of compressive with the licenses statement of compressive was provided to the representative and/acknowledgment had one client (#1) with the statement of compressive and statement of the clients. The on May 22, 23, and periodically observe services from employersonnel). Client #1 was admit August 11, 2014. The evidence to indicate representative were considered as the statement of the provided to the clients. The considered the statement of the clients of the clients of the clients of the clients. The considered the statement of the clients	provider cannot provide under ovider's license. The home in written acknowledgment it the provider has provided document why the provider eacknowledgment. The acknowledgment is not met as evidenced on, interview and record efailed to ensure a written rehensive home care services eclient and/or the client's for document why an ad not be obtained for one of records reviewed. The dient and does not affect and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all findings include:	0 835			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER	ING 300 SECO	DRESS, CITY, S DND STREET MN 55912	STATE, ZIP CODE - SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 835	Comprehensive ho services provided u client #1's record la written acknowledg On May 23, 2019, a employee B (housin and all other client the required inform A request was mad and/or procedures	me care provider, and the under the license. In addition, acked documentation why a ment had not be obtained. at approximately 8:35 a.m., and specialist) verified client #1, records lacked evidence of ation, as noted above. e for the licensee's policies for the provision of the es; however, none were	0 835			
0 905 SS=F	(21) days	R CORRECTION: Twenty-one 2 Provision of Medication Mgt	0 905			
	Subd. 2. Provision services. (a) For ear medication manage comprehensive hor providing medication have a registered in professional, or aut section 151.37 condetermine what me services will be provided. The conducted face-to-fassessment must in review of all medicataking. The review	of medication management ach client who requests ement services, the me care provider shall, prior to an management services, surse, licensed health thorized prescriber under duct an assessment of dication management vided and how the services his assessment must be face with the client. The include an identification and ations the client is known to be and identification must include ications, side effects,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	H25944		B. WING		05/2	4/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECC AUSTIN, I	ND STREET NN 55912	r SW		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 905	contraindications, a and actions to address (b) The assessmen needed in manager prevent diversion of medications who may have accomplished the contractions of medications means and actions to address and actions and actions to actions and actions are actions and actions are actions and actions and actions are actions and actions are actions as a second action actions are actions and actions actions are actions and actions are actions and actions are actions and actions are actions actions actions actions are actions actions actions actions are actions	allergic or adverse reactions,	0 905			
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a medication management assessment to include all the required content for one of one client (#2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On May 23, 2019, at approximately 8:15 a.m., client #2 was observed receiving medication					

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		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER TIONS ASSISTED LIV	ING 300 SECO	DRESS, CITY, S DND STREET MN 55912	STATE, ZIP CODE SW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 905	Client #2's diagnos limited to, schizoaff hypertension. The or November 19, 2018 medication manage Client #2's prescrib 21, 2018, included, antipsychotic, one a non-narcotic pain recommendation of the face-to face; and review of all medication if the face-to face; and review of all medications contraindications, a and actions to addronate of the face of face; and review of all medications contraindications, a and actions to addronate of the face	es included, but were not ective disorder, and client's "Service Plan," dated 3, indicated the client received ement services. er's orders, dated November but were not limited to: one antihypertensive; and one eliever. tion Assessment" dated acked following: assessment was conducted eastend following: assessment to for medications, side effects, ellergic or adverse reactions, ess these issue. at approximately 10:30 a.m., adicated the medication sed for client #2 was the fall clients. The employee and all other client records equired content. e to review the licensee assessment for clients wer, none were provided.	0 905	DEFICIENCY)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	ING	ND STREET VIN 55912	T SW		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 13	0 920			
0 920 SS=F	20 144A.4792, Subd. 5 Individualized Medication		0 920			
	plan. (a) For each of management service are provider must service plan a writter medication manage provided to the clie provider must deve individualized medieach client based on the contain the followin (1) a statement design management service (2) a description of on the client's need diversion, and consideractions; (3) documentation of relating to the admit (4) identification of monitoring medication refills and (5) identification of tasks that may be of personnel; (6) procedures for some a problem arises we services; and (7) any client-specifications	ement services that will be nt. The lop and maintain a current cation management record for client's assessment that must				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	H25944	B. WING		05/2	4/2019
REFLECTIONS ASSISTED LIVING 300 SECO		DRESS, CITY, S DND STREET MN 55912	TATE, ZIP CODE SW		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
prevent possible complications or advectory of the medication of current and updated changes. This MN Requirement by: Based on observation review, the licenseed management plans for one of one client. This practice resulted violation that did not safety but had the problems are pervastication are pervastication or all include: On May 23, 2019, and client #2 was observed administration from the personnel. Client #2's diagnose limited to, schizoaffer hypertension. The clinovember 19, 2018 medication manager.	nitoring of medication use to verse reactions. management record must be discontinuous and there are any ent is not met as evidenced on, interview and record failed to ensure medication included all required content (#2) with records reviewed. ed in a level two violation (at harm a client's health or otential to have harmed a fety, but was not likely to represent a systemic cited or has potential to affect of the clients). The findings of the clients of the client of	0 920			

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	24/2019	
	PROVIDER OR SUPPLIER	ING 300 SECC	DRESS, CITY, S DND STREET MN 55912	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
0 920	21, 2018, included, antipsychotic, one a non-narcotic pain records management plan hassessment that incepts and ensurordered on a timely. On May 23, 2019, a employee A (RN) verifindings. The employeent client records content. A request was made policies related to rehowever, none were the months of the content of the	but were not limited to: one antihypertensive; and one eliever. lacked a medication based on the medication cluded identification of e for monitoring medication ing that medication refills are a basis. at approximately 10:30 a.m., erified the above noted by everified client #2 and all a lacked the above required le to review the licensee medication management plan; e provided.	0 920				
0 945 SS=F	Subd. 10.Medication who will be away from the client's access develop and impler for giving accurate medications to clientimes away from ho	on management for clients om home. (a) A home care viding medication ces to the client and controls to the medications must ment policies and procedures	0 945				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	/ING	OND STREET MN 55912	r sw		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 945	Continued From pa	age 16	0 945			
	policy and procedu	res must state that:				
	be obtained from the registered nurse ac	e away, the medications must ne pharmacy or set up by the coording to appropriate state nd nursing standards of				
	is not able to provio nurse or unlicensed client or client's rep amounts and	me away, when the pharmacy de the medications, a licensed dipersonnel shall give the presentative medications in or the length of the anticipated deed 120 hours;				
	provided written infincluding any speci	indling the medications,				
	medication contain the provider's medication	s must be placed in a er or containers appropriate to on system and must be ent's name and the dates and heduled; and				
	provided in writing name and information on provider.	the home care provider's how to contact the home care				
	by:	ent is not met as evidenced				

Minnesota Department of Health STATE FORM

7GDO11 If continuation sheet 17 of 37

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	4/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECO AUSTIN, N	ND STREET IN 55912	SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 945	Based on interview licensee failed to en were developed, for medication manage accurate and curre planned times awardicensee failed to en procedure for giving medications to client from home was contained. This practice result violation that did not safety but had the policent's health or saw widespread scope or represent a system or has the potential of the clients). The On May 22, 2019, a (registered nurse/Received medication employee stated if away from home, a medication, the unlest-up the medication bubble medications with the clients would go out some clients would unplanned time away. The licensee failed policy and procedu from home to addresobtained from the procedure of the policy and procedured.	and record review, the insure policies and procedures or clients who received ement services, for giving int medications to clients for y from home. In addition, the insure the policy and gracurate and current ints for unplanned times away implete. Bed in a level two violation (and tharm a client's health or insured to have harmed a fety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all findings include: But 10:30 a.m., employee A and insured time in management services. The insured a scheduled in insured a scheduled in insured a scheduled in items and would send the eclient. Employee A verified to not a planned time away, and occasionally go out on an anay. It develop and implement a refor planned times away ess medications must be obarmacy or set up by the RN poriate state and federal laws	0 945			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	'ING 300 SECO AUSTIN, N	ND STREET IN 55912	- SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 945	Continued From pa	ige 18	0 945			
	implement a policy times away from hore-for unplanned times is not able to provious nurse or unlicensed the client or client's amounts and dosay the anticipated abshours; - the client or client provided written infincluding any special administering or harmonistering or harmonistering or harmonistering or container or container or container or container or container the client or client provided in writing name and informat home care provide On May 24, 2019, a employee B (housi licensee did not harmonistering accurate and for planned and unhome. No further informat	Indling the medications, a substances; must be placed in a medication ners appropriate to the on system and must be ent's name and the dates and cations are scheduled; and 's representative must be the home care provider's ion on how to contact the r. at approximately 11:30 a.m., and specialist) confirmed the ve a policy and procedure for discurrent medications to clients planned times away from				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
REFLECTIONS ASSISTED LIVING 300 SECO		DRESS, CITY, S DND STREET MN 55912	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 950	Continued From pa	ge 19	0 950			
0 950 SS=F		10(b) Medication Mgt for	0 950			
	nurse is not availab	ime away when the licensed le, the registered nurse may o unlicensed personnel if:				
	unlicensed staff and staff is	urse has trained the d determined the unlicensed the procedures for giving hts; 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 client.					
	The procedures mu	st address:				
		iner or containers to be used appropriate to the provider's				
	(ii) how the contained labeled;	er or containers must be				
		mation about the medications lient or client's representative;				
	the client's record the given to the client or the client or the client or the client document were given to	sed staff must document in hat medications have been client's representative, ting the date the medications ent's representative and who				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER TIONS ASSISTED LIV	ING 300 SECO	DRESS, CITY, S DND STREET WN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 950	received the medications to the medications to the medications that we other required information; (v) how the register medications have be client's representationaries needs to be of medications are given to the client of and (vi) a review by the completion of this tacompleted accurate personnel. This MN Requirements by: Based on interview licensee failed to en personnel/ULP (D) nurse (RN), and had to setup and give munplanned times and the written procedure by the RN as required by the RN as req	ations, the person who gave client, the number of ere given to the client, and red nurse shall be notified that been given to the client or live and whether the registered contacted before the east to verify that this task was ely by the unlicensed ent is not met as evidenced and record review, the ensure one of one unlicensed was trained by the registered demonstrated competency nedications to clients for way from home. In addition, res had not been developed	0 950			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	05/2	4/2019
	TIONS ASSISTED LIV	300 SECO	ND STREET			
KEFLEG		AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 950	Continued From pa	ge 21	0 950			
	a large portion or a include:	Il of the clients). The findings				
	(registered nurse/R received medication employee stated if away from home, a medication, the unl set-up the medication bubble medications with the clients would go out some clients would unplanned time aw Employee D was his 31, 2017, to provide employee's records employee had been demonstrated compedications for clients way.	red by the licensee on May e direct cares to client. The slacked evidence the notation trained by the RN and had betency to sets up ents with unplanned times				
	and procedure for the for clients for unplated addressed the follough the type of contains for the medications medication system:	ner or containers to be used appropriate to the provider's				
	labeled; - the written information be given to the clienten to the clienten client's record that to the client or the clienten to the client or the clienten to the clienten t	ation about the medications to nt or client's representative; ed staff must document in the medications have been given client's representative, ting the date the medications				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/24/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
REFLEC	TIONS ASSISTED LIV	ING 300 SECC AUSTIN, I	ND STREET NN 55912	· sw		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	HOULD BE COMPLETE	
0 950	medications that we other required infor- how the registered medications have be client's representat nurse needs to be a medications are given representative; and a review by the recompletion of this to completed accurate personnel. On May 24, 2019, a employee B (housing above noted finding No further informations)	lient or the client's who received the erson who gave the client, the number of ere given to the client, and mation; d nurse shall be notified that been given to the client or even given to the client or even to the client or the client or the client or the client's ligistered nurse of the eask to verify that this task was ely by the unlicensed at approximately 11:30 a.m., and specialist) verified the egs.	0 950			
01010 SS=F	, , , , , , , , , , , , , , , , , , ,	22 Disposition of Medications	01010			
	current medications comprehensive hor given to the client of when the client's semanagement service service plan. Medic in the client's private is deceased or that that have expired n	on of medications. (a) Any is being managed by the me care provider must be or the client's representative ervice plan ends or medication ces are no longer part of the cations that have been stored the living space for a client who have been discontinued or may be given to the client or intative for disposal.				

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Minnesota Department of Health						a
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H25944	B. WING		05/24/2019	
NAME OF I	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY S	STATE, ZIP CODE		
NAME OF I	- NOVIDEN ON SUFFEIEN		ND STREET			
REFLEC	TIONS ASSISTED LIV	ING	VIN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01010	Continued From pa	ge 23	01010			
	dispose of any med comprehensive hor discontinued or exp of the service contraccording to state a disposition of medic substances. (c) Upon disposition care provider must record the disposition the medication's nanumber as applicate medications were go	sive home care provider will dications remaining with the me care provider that are bired or upon the termination act or the client's death and federal regulations for cations and controlled on, the comprehensive home document in the client's on of the medication including time, strength, prescription ole, quantity, to whom the given, date of disposition, and other individuals involved in				
	by: Based on interview licensee failed to endisposition of medic required information client (#3) with recommendations.					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	ING 300 SECC AUSTIN, N	ND STREET MN 55912	T SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01010	Continued From pa	ge 24	01010			
	1, 2019. The client' documentation of the to include: medication prescription number	ne disposition of medications				
	Client #3's prescriber order dated January 9, 2019, included, but was not limited to, the following medications: one antipsychotic, two antihypertensive, and one non-narcotic pain reliever.					
	Client #3's "Discharge Summary" dated May 1, 2019, indicated the client's medications were sent with the client at the time of discharge. The record lacked documentation of the disposition of the medications as noted above.					
	On May 23, 2019, at approximately 10:30 a.m., employee A (registered nurse) and B (housing specialist) verified client #3's record lacked documentation of medication disposition to include all the required content.					
	dated June 3, 2015	position of Medication" policy, i, instructed staff to document nclude the above noted				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01145 SS=F	144A.4795, Subd. Evals All Staff	7(b) Training/Competency	01145			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		H25944	B. WING		05/24/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DEEL EC	TIONS ASSISTED LIV	ING 300 SECO	OND STREET	sw		
KLI LLO	TIONS ASSISTED LIV	AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
01145	Continued From pa	ge 25	01145			
	unlicensed personr (1) documentation provided; (2) reports of change	mpetency evaluations for all nel must include the following: requirements for all services ges in the client's condition to gnated by the home care				
	the supervisor designated by the home care provider; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and					
	(6) training on the pworking with the eld falls; (7) standby assistate perform them; (8) medication, exereminders; (9) basic nutrition, rand assistance with (10) preparation of a licensed health period (11) communication the dignity of the client and the control background, and faction (12) awareness of (13) understanding between staff and control to the client and the control to the client an	modified diets as ordered by rofessional; a skills that include preserving tent and showing respect for lient's preferences, cultural mily; confidentiality and privacy; appropriate boundaries clients and the client's family; utilize in handling various				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	4/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
REFLECTIONS ASSISTED LIVING			ND STREET IN 55912	· SW		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01145	Continued From pa	ge 26	01145			
		commonly used health ent and assistive devices.				
	by:	ent is not met as evidenced				
	Based on observation, interview and record review, the licensee failed to ensure competency evaluations were completed by the registered nurse (RN) in all the required areas for one of one unlicensed personnel/ULP (D).					
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include:					
		petween 8:30 and 9:00 a.m., oserved providing medication lents.				
	Employee D was hired on May 31, 2017. The employee's record lacked evidence competency evaluations had been completed by a RN prior to the provision of client care to include the following: - 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; and - standby assistance techniques and how to perform them.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER	ING 300 SECO	OND STREET	STATE, ZIP CODE		
1(2, 220	TIONO AGGIOTED EN	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01145	On May 23, 2019, a employee A (RN) are verified the above representation of the Arequest was mad policies and proceded competency evaluation of the topics; however the components of the topics of th	at approximately 10:30 a.m., and B (housing specialist) noted findings. The employees e requirement. e to review the licensee's lures for training and tions of ULP for of the above wer, none were provided.	01145			
01150 SS=F	Evals Comp Staff (c) In addition to paragraphic competency evaluated providing comprehence in the competency evaluated providing comprehence in the competence in the compete	ording temperature, pulse,	01150			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D WING			
		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER	300 SECO	DRESS, CITY, S IND STREET	STATE, ZIP CODE F SW		
REFLEC	TIONS ASSISTED LIV	ING AUSTIN, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01150	Continued From page 28		01150			
	by: Based on observati review, the licensed evaluations were co nurse (RN) in all the one unlicensed per This practice result violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ion, interview and record e failed to ensure competency ompleted by the registered e required areas for one of sonnel/ULP (D). ed in a level two violation (a ot harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings				
		between 8:30 and 9:00 a.m., oserved providing medication ients.				
	employee's record evaluations had be to the provision of of following: - reading and recor respirations of the of - safe transfer tech - range of motioning	niques and ambulation; and g and positioning.				
	employee A (RN) a verified the above r were unaware of th	·				
	A request was mad	e to review the licensee's				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	ING 300 SECC AUSTIN, I	ND STREET NN 55912	SW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01150	Continued From page 29		01150			
	competency evalua noted topics; howe	lures for training and tions of ULP for of the above ver, none were provided.				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
01170 SS=D	144A.4796, Subd. 2	2 Content of Orientation	01170			
	topics: (1) an overview of s 144A.4798; (2) introduction and policies and proced of home care service (3) handling of eme emergency service (4) compliance with maltreatment of mir under sections 626 (5) home care bill o 144A.44; (6) handling of clier complaints, and wh including information Facility Complaints (7) consumer advoic Ombudsman for Lo Ombudsman for Mo Developmental Dis Ombudsman at the Services, county m other relevant advoic (8) review of the type	review of all the provider's lures related to the provision ces; ergencies and use of s; and reporting of the nors or vulnerable adults .556 and 626.557; frights under section ats' complaints, reporting of ere to report complaints on on the Office of Health and the Common Entry Point; cacy services of the Office of ong-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/24/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
REFLEC	TIONS ASSISTED LIV	ING	OND STREET VIN 55912	sw		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01170	scope of licensure. (b) In addition to the (a), orientation may providing services to Any training on heat subdivision must be research-based, may must include training following topics: (1) an explanation of and how it manifest challenges it poses (2) health impacts of age-related hearing incidence of demer isolation, and depre (3) information about that may enhance of involvement, includ assistive listening of and tactile alerting	e topics listed in paragraph also contain training on to clients with hearing loss. It in loss provided under this e high quality and ay include online training, and ig on one or more of the of age-related hearing loss is itself, its prevalence, and to communication; related to untreated gloss, such as increased that, falls, hospitalizations, ession; or ut strategies and technology	01170			
	by: Based on observati review, the licensee	ent is not met as evidenced on, interview and record e failed to ensure one of three eived orientation to home care s.				
	violation that did no safety but had the	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019
	PROVIDER OR SUPPLIER	300 SECO	ND STREET	STATE, ZIP CODE SW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01170	cause serious injury was issued at an is limited number of climited number of situation has occurry findings include: On May 23, 2019, the employee D was obtain administration to climited to climite the employee's record indicate the employorientation to home an overview of second indicate the employee will be proscope of licensure. On May 23, 2019, a employee A (register specialist) verified to the content of the conten	y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The between 8:30 and 9:00 a.m., oserved providing medication ents. The lacked documentation to ree had received the following care training: etions 144A.43 to 144A.4798; as of home care services the oviding and the provider's at approximately 10:30 a.m., ered nurse) and B (housing he above noted findings. The to review the licensee's lures for home care above noted topics; e provided.	01170	DEFICIENCY		
01225 SS=F	. , .	3 Supervision of Staff - Comp	01225			

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Minnesota Department of Health

	IT OF DEFICIENCIES	T	(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	-		A. BUILDING:			
			5 14/15/6			
		H25944	B. WING		05/2	4/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DEE: 50	TIONO 40010TED I IV	300 SECC	ND STREET	r sw		
REFLEC	TIONS ASSISTED LIV	'ING AUSTIN, I	MN 55912			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				,		
01225	Continued From pa	ige 32	01225			
	Subd. 3. Supervision	on of staff providing delegated				
	nursing or therapy	home care tasks. (a) Staff				
		ated nursing or therapy home				
		supervised by an appropriate				
		fessional or a registered nurse				
		the services are being				
		nat the work is being				
		ently and to identify problems ed to the staff person's ability				
		s. Supervision of staff				
	performing medicat					
		be provided by a registered				
		e licensed health professional				
	and	•				
	must include obser	vation of the staff				
		nedication or treatment and				
	the interaction with					
	the client.					
	(h) The direct sune	rvision of staff performing				
		ust be provided within 30 days				
	after					
	the individual begin	s working for the home care				
	provider and therea	after as needed based on				
	performance.					
		lso applies to staff who have				
	-	gated tasks for one year or				
	longer.					
	This MN Requireme	ent is not met as evidenced				
	by:	Cit. 13 HOLHICL 43 EVIGENCE				
		ion, interview and record				
		e failed to ensure a registered				
		d supervision of staff				
		ed tasks within 30 days of hire				
		ensed personnel/ULP (D).				
		ed in a level two violation (a				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H25944	B. WING		05/2	4/2019	
REFLECTIONS ASSISTED LIVING 300 SECO			DDRESS, CITY, STATE, ZIP CODE COND STREET SW MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01225	safety but had the policies and procedunicensed personre provided. Safety but had the policies and procedunicensed personre provided. Safety but had the policies accause serious injury was issued at a wide problems are perversed along the provided and all other employee. Employee D was his services to clients of employee's record supervision of delet completed by the Remployee had begundered by the Remployee had begundered by the Remployee D was of administration to clients of the provided and all other employee A (register specialist) verified on the provided and all other employee and procedunicensed person provided. No further informations are person provided.	potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect ll of the clients). The findings ared to provide home care on May 31, 2017. The lacked evidence direct gated tasks had been an area of the licensee's clients. The determinant of the licensee's clients are approximately 10:30 a.m., ared nurse) and B (housing direct supervision of staff had within 30 days for employee D yees. The employees were uirement. The to review the licensee's lures for supervision of staff had within 30 days for employee D yees. The employees were uirement.	01225				

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NUMBER: A. BUILDING	<u> </u>	(X3) DATE SURVEY COMPLETED		
B. WING	B. WING		05/24/2019	
	STATE ZID CODE	1 03/2	4/2013	
AUSTIN, MN 55912				
BY FULL PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
01245				
nd Control 01245				
establish entrol uidelines vention on and ome care etime of hire tion, and en TB make the et to home tte.				
n and on and urrent Disease ude a facility usee failed had a u, completed iolation (a ealth or				
	300 SECOND STREET AUSTIN, MN 55912 CIES BY FULL RMATION) PREFIX TAG 01245	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SECOND STREET SW AUSTIN, MN 55912 DES PULL PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDENCY) 101245 Ind Control 01245 Independence of time of hire of h	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SECOND STREET SW AUSTIN, MN 55912 DIES FULL PREFIX TAG O1245 INMATION) O1245 INMATION INMATION O1245 INMATION O1245 INMATION O1245 INMATION INMAT	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
H25944		H25944	B. WING		05/24/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
REFLEC	TIONS ASSISTED LIV	ING	OND STREET WN 55912	· sw			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01245	was issued at a wide problems are pervaluation for a large portion or a include: TB RISK ASSESS On May 22, 2019, a employee B (Housi (registered nurse) was components of the control program to assessment. TST Employee D was his employees record ITST had been common May 23, 2019, a employee D was obtain a management of the control program to assessment. On May 23, 2019, a employee D was obtained a current assessment. The ethe requirement. In verified employee D was made to be record lacked a two control program to assessment. The ethe requirement. In verified employee D was obtained as the requirement of the req	y, impairment, or death), and despread scope (when asive or represent a systemic acted or has potential to affect II of the clients). The findings MENT at approximately 12:00 p.m., ng Specialist) and employee A were unable to report licensees TB prevention and include the facility risk ired on May 31, 2017, the acked evidence a two-step pleted. Detween 8:30 and 9:00 a.m., oserved providing medication ients. at approximately 10:30 a.m., verified the licensee had not at written facility TB risk mployees were unaware of addition, employee A and B D had been working with a fine, and the employee's ostep TST. The to review the licensee TB prevention and control; ee hade policies for TB trol, none were provided.	01245				
	No further information was provided.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		H25944	B. WING		05/2	24/2019
	PROVIDER OR SUPPLIER TIONS ASSISTED LIV	ING 300 SEC	ODRESS, CITY, S OND STREET MN 55912	STATE, ZIP CODE F SW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01245	,	ge 36 R CORRECTION: Seven (7)	01245			

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