Electronically Delivered

April 24, 2025

Licensee

Good Samaritan Society - Heritage Grove
2122 River Road Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL24554016

Dear Licensee:

On April 16, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2024, survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last , completed on , found not corrected at the time of the April 16, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0830-Local Laws Apply-144g.45 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on April 16, 2025 (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.

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-HERITAG	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY INITIAL COMMENTS SL#24554016-1 On April 14, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2024. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a	{0 100}		

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{0 100}	Continued From page 1 campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 100}		
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has	{0 620}		

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{0 620}	Continued From page 2 been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common	{0 620}		

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{0 620}	Continued From page 3 entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 620}		
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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.	{0 650}		

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{0 650}	Continued From page 4 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 5 (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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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: Not reviewed during this survey.	{0 810}		
{0 830} SS=D	144G.45 Subd. 3 Local laws apply	{0 830}		

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{0 830}	Continued From page 6 Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to submit a plan review application for a facility renovation project. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 14, 2025, at 7:47 a.m., the surveyor emailed the licensee requesting an update on corrections completed for the 0830 tag pursuant to a survey completed on December 6, 2024. On April 15, 2025, at 6:55 a.m., licensed assisted living director (LALD)-A responded our plan of correction at this time is we have ceased all work on this project until the proper paperwork has been submitted and approved. The room is locked and not accessible to residents.	{0 830}		

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{0 830}	Continued From page 7 FINDINGS FROM PREVIOUS SURVEY: On December 6, 2024, at 9:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-D. During the tour of the Pines building, the surveyor observed the tub room was under renovation and there was a rectangular hole in the wall on the interior side of this room. LALD-A stated during the facility tour interview on December 6, 2024, the tub room was being renovated into a general store and installation of a service window between the tub room and corridor was planned. LALD-A verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the project. No further information was provided.	{0 830}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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.	{01290}		

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{01290}	Continued From page 8 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01290}		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01710}		
{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 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	{01730}		

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{01730}	Continued From page 9 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: Not reviewed during this survey.	{01730}		
{01880} SS=D	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:	{01880}		

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{01880}	Continued From page 10 Not reviewed during this survey.	{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: Not reviewed during this survey.	{01890}		

Electronically Delivered

January 27, 2025

Licensee
Good Samaritan Society-Heritage Grove
2122 River Road Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL24554016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Good Samaritan Society-Heritage Grove. Please contact Jessie Chenze at 218-332-5175 on or before Thursday, January 30, 2025, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

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0 000	Initial Comments 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: SL24554016-0 On December 2, 2024, through December 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 84 residents; 36 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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	24554	A. BUILDING: _____ B. WING _____	12/06/2024

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of the facility space to operate a home care agency. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 2, 2024, at 10:37 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On December 2, 2024, from 11:47 a.m. through 12:20 p.m., the surveyor toured the facility with LALD-A consisting of three buildings (Oaks, Pine, Maple), which were all interconnected from the inside by hallways. On the second floor in the Oaks building, signage was posted at the #210 apartment door, which indicated the apartment was used as a home care office. LALD-A stated that apartment was used for a sister agency home care office, the home care agency had their	0 100		

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0 100	Continued From page 3 own staff, and the home care agency staff were not employees of the assisted living. On December 6, 2024, at 12:38 p.m., the engineer surveyor stated a home care office was located in the Oak's building at apartment #210 with no separation between the home care office and resident apartments at the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	0 620		

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0 620	Continued From page 4 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the	0 620		

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0 620	Continued From page 5 Minnesota Adult Abuse Reporting Center (MAARC) an unaccounted narcotic loss from one of one resident (R5). 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 December 2, 2024, at 10:51 a.m., licensed assisted living director (LALD)-A stated all narcotic medication was stored in a locked box in the locked medication room and counted at each shift change. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated November 29, 2024, indicated the licensee admitted R5 on September 1, 2023, and R5 was discharged on July 8, 2024. R5's diagnoses included anxiety and hypertension (HTN-high blood pressure). R5's Service Plan dated June 4, 2024, indicated R5 received medication management services to include medication administration daily. R5's Nursing Assessment and Level of Care Evaluation dated June 24, 2024, indicated staff would manage all R5's medications. In addition, an intervention was to educate resident and/or	0 620		

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0 620	Continued From page 6 resident's legal or designated representative to prevent medication theft and diversion by keeping medications in a secure area and locking the door to their (R5's) unit when out. R5's prescriber orders dated June 6, 2024, included an order for lorazepam 0.5 milligrams (mg) tablet to be administered by mouth two times per day as needed (PRN) for anxiety. R5's Medication Error Report Form dated June 20, 2024, at 10:00 p.m., had written R5's "lorazepam 0.5 mg count supposed to be 20 but was 19. RN (registered nurse) notified, count is now corrected." In addition, the report indicated a critical incident notification was not applicable, however, the report had written "If missing medication is a controlled substance, a full investigation is required." The full investigation needed for yes or no boxes were left blank, and the Medication Error Report Form was signed by clinical nurse supervisor (CNS)-H on June 24, 2024. R5's Medication Administration Record (MAR) dated June 2024, had documentation R5 received a lorazepam 0.5 mg tablet three times (June 14, 2024, June 17, 2024, and June 19, 2024) between June 14, 2024, through June 20, 2024. R5's Individual Resident's Narcotic Record listed the following entries for lorazepam 0.5 mg give one tablet by mouth: -June 14, 2024, at 1822 (6:22 p.m.), one lorazepam 0.5 mg was signed out by one staff member and 22 lorazepam tablets remained; -June 17, 2024, at 1800 (6:00 p.m.), one lorazepam 0.5 mg was signed out by one staff member and 21 lorazepam tablets remained;	0 620		

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0 620	Continued From page 7 -June 19, 2024, at 1800 (6:00 p.m.), one lorazepam 0.5 mg was signed out by one staff member and 20 lorazepam tablets remained; and -June 22, 2024, at 800 [sic] (8:00 a.m.), indicated "corrected count" and 19 lorazepam tablets remained, however, R5's MAR dated June 2024 did not have documentation of an additional dose of lorazepam 0.5 mg tablet being administered after June 19, 2024. The licensee lacked documentation of a MAARC report for R5's lorazepam 0.5 mg tablet that was discovered to be missing between June 19, 2024, at 6:00 p.m. through June 22, 2024, at 8:00 a.m. On December 3, 2024, at 2:59 p.m., CNS-H stated CNS-H searched R5's entire room and went through all R5's medications, however, CNS-H was unable to locate R5's missing lorazepam 0.5 mg tablet. CNS-H further stated CNS-H retrained all staff on controlled substance sign out, and implemented the need for two staff to sign off at every shift change or for a controlled substance administration. CNS-H stated CNS-H did not file a MAARC report since CNS-H was confident the two staff members working on June 20, 2024, did not take the missing lorazepam 0.5 mg tablet. The licensee's Loss or Spillage of Controlled Substances, AL (assisted living)- Enterprise policy dated September 30, 2024, indicated when loss or spillage of a controlled substance occurs, the licensed nurse and senior living (SL) manager must be notified. In addition, an explanatory note must be made in the Individual Resident's Narcotic Record for that medication by the person responsible for the loss or spillage. Both the licensed nurse and SL manager will initial the entry.	0 620		

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0 620	Continued From page 8 The licensee's Vulnerable Adults, Reporting Maltreatment, Assisted Living- Minnesota policy dated April 18, 2024, indicated assisted living providers who are licensed under the Minnesota Department of Health (MDH) are required (mandated) to report all vulnerable adult maltreatment allegations to the single common entry point, MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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0 650	Continued From page 9 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-E, ULP-C). 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 December 2, 2024, at 10:55 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record. ULP-E ULP-E was hired on March 3, 2010, and had begun to provide direct assisted living services to residents at the facility on August 1, 2021. On December 2, 2024, at 1:41 p.m., the surveyor observed ULP-E empty R3's nephrology catheter bags (a thin, flexible tube that is inserted into the kidneys allowing urine to drain from the kidney into a collection bag outside of the body). ULP-E's record lacked training and a competency	0 650		

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0 650	Continued From page 10 evaluation for nephrology catheters. On December 2, 2024, at 1:53 p.m., ULP-E stated ULP-E was trained and completed competency testing by a registered nurse (RN) for R3's nephrology catheter cares when R3 began receiving services. On December 3, 2024, at 2:51 p.m., clinical nurse supervisor (CNS)-H stated all ULPs were trained and competency tested to complete R3's nephrology cares when R3 started services, however, CNS-H did not document the training or competency in the ULP's employee records. CNS-H further stated CNS-H had thought the documentation for a foley catheter (a thin, flexible tube inserted into the bladder to drain urine) would be sufficient documentation to cover the nephrology catheter as well. ULP-C ULP-C was hired on December 14, 2023, to provide direct assisted living services to residents at the facility. On December 3, 2024, at 9:13 a.m., the surveyor observed ULP-C complete scheduled morning medication administration for R10. ULP-C's employee record lacked documentation of training and a competency evaluation for resident's unplanned time away. On December 3, 2024, at 7:42 a.m., ULP-C stated ULP-C was trained and competency tested for medication administration, including unplanned time away, upon hire with CNS-H. On December 3, 2024, at 2:56 p.m., CNS-H stated all ULPs had been trained and	0 650		

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0 650	Continued From page 11 competency tested on unplanned time away at hire and reviewed at staff meetings, however, CNS-H stated the licensee did not document the unplanned time away training and competency in any of the ULP's employee records. The licensee's Required Training for All Employees, Minnesota- Assisted Living policy dated July 8, 2024, indicated the assisted living facility shall retain evidence in the employee record of each staff person having completed the orientation and training required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described	0 650		

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0 650	Continued From page 12 in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with smoke alarm requirements	0 780		

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0 780	Continued From page 13 and Minnesota Fire Code, Minnesota Rules 7511. 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 of the residents). The findings include: On December 6, 2024, at 9:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-D. During the tour, the surveyor observed the following: 1. When the smoke alarms were tested by DM-D in resident apartment 208 in the Heritage Maples building, the other smoke alarms in the apartment were not actuated. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview on December 6, 2024, DM-D verified the above listed smoke alarm observation. 2. The door closer was disconnected on the labeled fire door for the dietary office in the Pines building. 3. The door closer had been removed from the labeled 20 minute fire door for resident apartment 109 in the Oaks building. 4. The door closer had been removed from the labeled 20 minute fire door for the home care office/room 210 in the Oaks building. 5. A door closer was not installed on the trash room door in the Oaks building. Holes were	0 780		

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0 780	Continued From page 14 observed in the door trim installed above the door. 6. Extension cords were used to supply power in resident apartments 102 and 108 in Heritage Maples, and 109 in Oaks. During the facility tour interview on December 6, 2024, DM-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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	0 810		

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0 810	Continued From page 15 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 6, 2024, licensed assisted living director (LALD)-A and director of maintenance (DM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year after hire evident by the lack of training	0 810		

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0 810	Continued From page 16 documentation. During an interview on December 6, 2024, at 12:30 p.m., LALD-A stated employees were trained during fire drills and employee FSEP training had not been completed in the last year. Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review. During an interview on December 6, 2024, at 12:30 p.m., LALD-A stated residents were trained on fire safety and evacuation but records were not available to support this had been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to submit a plan review application for a facility renovation project. This had the potential to directly affect more than a limited number of	0 830		

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0 830	Continued From page 17 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 6, 2024, at 9:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and director of maintenance (DM)-D. During the tour of the Pines building, the surveyor observed the tub room was under renovation and there was a rectangular hole in the wall on the interior side of this room. LALD-A stated during the facility tour interview on December 6, 2024, the tub room was being renovated into a general store and installation of a service window between the tub room and corridor was planned. LALD-A verified a plan review application had not been submitted to Minnesota Department of Health Engineering Services for the project. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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01290	Continued From page 18 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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 affiliated with the correct health facility identification (HFID) for one of 29 employees (registered nurse (RN)-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, 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 December 2, 2024, at 10:55 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee record.	01290		

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01290	Continued From page 19 RN-B was hired on April 17, 2023, to provide RN on-call services for staff and residents at the facility. RN-B was licensed by the Minnesota Board of Nursing as an RN effective July 7, 2015. The licensee's NETStudy 2.0 Roster Report printed December 2, 2024, at 11:30 a.m., did not list RN-B as a current employee. RN-B's employee record contained a cleared background study notice issued by the Minnesota Department of Human Services dated July 9, 2021. The background study was affiliated to a sister facility with the HFID 20656. RN-B's employee record lacked a cleared background study affiliated to the licensee. On December 3, 2024, at 2:48 p.m., LALD-A stated RN-B was not listed on the licensee's NETStudy 2.0 roster for HFID 24554, however, RN-B had a cleared background study through the licensee's sister facility, and LALD-A was not aware RN-B needed to be affiliated with each location. The licensee's Hiring and Screening- Enterprise policy dated March 24, 2022, indicated human resources will conduct background checks on all new employees. The background checks included local and state-specific background and/or registry checks. The policy did not address affiliating employee's background study at multiple sister locations of the licensee. No further information was provided.	01290		

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01290	Continued From page 20 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reassessed residents for appropriate medication management services when resident status changed for one of four residents (R8) 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, 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 December 2, 2024, at 10:44 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at	01710		

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01710	Continued From page 21 the facility. R8's diagnoses included hypertension (HTN- high blood pressure), diabetes, depression, and bipolar disorder. R8's Service Plan dated January 20, 2023, indicated R8 received medication management services and medication administration daily. R8's record lacked a prescriber order for Metamucil. R8's Nursing Assessment and Level of Care Evaluation Annual Review dated August 22, 2024, indicated R8 did not independently manage or partially manage R8's medications and staff would manage (order, store, setup, and administer) medications. The assessment further indicated R8 was independent with self-administration of nystatin external powder and melatonin. On December 3, 2024, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-E provide scheduled morning medication administration to R8. The surveyor observed an opened container of Metamucil powder on R8's refrigerator. ULP-E stated ULP-E never noticed the container of Metamucil on R8's refrigerator, and ULP-E believed R8 took Metamucil independently since the Metamucil was not listed on R8's electronic medication administration record (EMAR). R8's record lacked evidence R8 was assessed for self-administration of Metamucil. In addition, R8's record lacked evidence R8 was assessed to store Metamucil in R8's room. On December 4, 2024, at 2:22 p.m., clinical nurse	01710		

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01710	Continued From page 22 supervisor (CNS)-H stated CNS-H was not aware or informed R8 had Metamucil in R8's room. CNS-H stated the licensee reviewed individual medication management plans and medication assessments yearly unless a resident had a change in medication, and R8 should have had a new assessment completed when R8 had begun to take Metamucil to assure R8 could store Metamucil in R8's apartment and complete self-administration of Metamucil safely. The licensee's Self-Administration of Medications- Assisted Living policy dated September 5, 2023, indicated a resident who chooses to self-administer medications will be assessed by an RN for their ability to safely administer their own medication. The licensee's Medications Acquisition, Receiving, Packaging, and Storage, AL (assisted living)-Enterprise policy dated September 23, 2024, indicated medications will be stored in a locked medication cart, drawer, or cupboard. In addition, medications may be stored in the resident's unit, but will need to be secured according to state regulations. This applies to residents who have their medications administered, as well as those who self-administer their medications or receive assistance with self-administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 23 (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 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	01730		

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01730	Continued From page 24 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 plan for each resident to include all required content for one of four residents (R8). 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 December 2, 2024, at 10:44 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. R8's diagnoses included hypertension (HTN- high blood pressure), diabetes, depression, and bipolar disorder. R8's Service Plan dated January 20, 2023, indicated R8 received medication management services and medication administration daily. R8's record lacked a prescriber order for Metamucil. R8's Nursing Assessment and Level of Care	01730		

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01730	Continued From page 25 Evaluation Annual Review dated August 22, 2024, indicated R8 did not independently manage or partially manage R8's medications and staff would manage (order, store, setup, and administer) medications. The assessment further indicated R8 was independent with self-administration of nystatin external powder and melatonin, and medications were reconciled upon admission, post-hospitalization, and when provider renews orders annually. On December 3, 2024, at 8:29 a.m., the surveyor observed unlicensed personnel (ULP)-E provide scheduled morning medication administration to R8. The surveyor observed an opened container of Metamucil powder on R8's refrigerator. ULP-E stated ULP-E never noticed the container of Metamucil on R8's refrigerator, and ULP-E believed R8 took Metamucil independently since the Metamucil was not listed on R8's electronic medication administration record (EMAR). R8's record lacked evidence of an updated medication reconciliation after R8 had begun using Metamucil. On December 4, 2024, at 2:22 p.m., clinical nurse supervisor (CNS)-H stated CNS-H was not aware or informed R8 had Metamucil in R8's room. CNS-H stated the licensee reviewed individual medication management plans and medication assessments yearly unless a resident had a change in medication, and R8 should have had a new assessment completed when R8 had begun to take Metamucil. The licensee's Resident Medical Record Documentation Requirements- Minnesota policy dated August 21, 2024, indicated a registered nurse (RN) must reassess or review a resident as	01730		

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01730	Continued From page 26 needed based on resident's needs and use the Uniform Assessment Tool. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=D	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:	01880		

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01880	Continued From page 27 Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 December 2, 2024, at 10:44 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. R6's diagnoses included diabetes. R6's service plan dated January 13, 2024, included staff completed medication administration and insulin injections daily. R6's Nursing Assessment and Level of Care Evaluation dated November 13, 2024, indicated medication-trained staff to manage medication storage and security. Locked red box (where medications were stored) in R6's apartment. On December 3, 2024, at 6:57 a.m., the surveyor observed unlicensed personnel (ULP)-G administer scheduled morning medication administration to R6. ULP-G opened an unlocked	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-HERITAG	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

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01880	Continued From page 28 closet in R6's apartment, removed a locked red box that contained R6's oral medications, and removed R6's insulin pen from an unlocked tote. ULP-G administered R6's insulin, placed the insulin pen back into the unlocked tote located in R6's closet. On December 3, 2024, at 7:16 a.m., ULP-G stated R6's opened insulin pens were always stored in the tote next to the red locked medication box in R6's closet. On December 3, 2024, at 10:46 a.m., ULP-C stated R6's opened insulin pens were never stored the red locked medication box in R6's closet, however, other residents stored their insulin pens in the red locked medication box. On December 3, 2024, at 2:43 p.m., clinical nurse supervisor (CNS)-H stated all opened insulin pens should be stored in the resident's locked red medication box unless the resident self-managed insulin administration. The licensee's Medications Acquisition, Receiving, Packaging, and Storage, AL (assisted living)-Enterprise policy dated September 23, 2024, indicated medications will be stored in a locked medication cart, drawer, or cupboard. In addition, medications may be stored in the resident's unit, but will need to be secured according to state regulations. This applies to residents who have their medications administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	12/06/2024

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01890	Continued From page 29	01890		
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 ensure medications were maintained with legible information including the opened date and expiration date for time sensitive medications for one of two residents (R11). In addition, the licensee failed to monitor for expired medications in two of two secured medication storage rooms. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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 December 2, 2024, at 10:44 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	12/06/2024

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01890	Continued From page 30 TIME SENSITIVE MEDICATIONS On December 3, 2024, at 10:32 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R11's scheduled morning medications, including R11's Novolog 100 units/milliliter (mL) insulin pen. R11's opened Novolog insulin pen was not labeled with the opened date or expiration date the Novolog insulin pen would expire. On December 3, 2024, at 10:40 a.m., ULP-C stated R11's opened Novolog insulin pen should have been dated with the open date of the Novolog insulin pen. EXPIRED MEDICATIONS On December 3, 2024, at 1:27 p.m., the surveyor reviewed the Pine medication storage room with ULP-F and observed the following: -one opened bottle of R12's Tylenol 500 milligrams (mg) expired June 2023; -one opened tube of R8's triamcinolone acetonide 0.1% cream expired June 2023; -one opened bottle of R14's Airborne tablets expired September 2019; and -one opened bottle of R14's Vitamin C 1,000 mg expired November 2024. On December 3, 2024, at 1:39 p.m., the surveyor reviewed the Maple medication storage room with ULP-F and observed the following: -one opened container of R15's Aquaphor expired September 2024; and -one opened bottle of R15's daily vitamin expired March 2024. Immediately following the observations, ULP-F stated the above noted medications were expired and typically the nurse reviewed the medication	01890		

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01890	Continued From page 31 storage rooms to monitor for expired medications. On December 4, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-H stated ULPs were trained to document the open date on all insulin pens when a new insulin pen was opened. CNS-H further stated CNS-H had reviewed both medication storage rooms "a few months back" to monitor for expired medications and the expectation was for ULPs to check all medication expiration dates prior to administering any medication to a resident. The manufacturer's instructions for Novolog dated November 2021, indicated once the Novolog insulin pen was opened for use, the Novolog insulin pen should be thrown away after 28 days even if it still has insulin left in it. The licensee's Insulin Preparation and Administration, AL (assisted living)- Enterprise policy dated June 28, 2024, indicated prior to insulin administration staff should verify the expiration date and number of days the pen (insulin pen) has been opened. The licensee's Medications Acquisition, Receiving, Packaging, and Storage, AL (assisted living)- Enterprise policy dated September 23, 2024, indicated all medications will be stored in accordance with manufacturers' recommendations. In addition, the ALC (assisted living community) will routinely check for expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St Paul, MN, 55164
218-332-5150

Type: Full
Date: *12/03/24*
Time: 07:35:40
Report: 1042241052

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society Heritag
2122 River Road NW
East Grand Forks, MN56721
Polk County, 60

Establishment Info:
ID #: 0012905
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
The Evangelical Lutheran Good

Phone #:
ID #: 11581

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Bucket
Violation Issued: No

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Hot Water: = at 173.3 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Hot Water: = at 167.5 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 192.7 Degrees Fahrenheit - Location: Casserol with Rice and Chicken
Violation Issued: No

Process/Item: Hot Holding
Temperature: 166.9 Degrees Fahrenheit - Location: Butter Peas
Violation Issued: No

Type: Full
Date: *12/03/24*
Time: 07:35:40
Report: 1042241052
Good Samaritan Society Heritag

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 37.1 Degrees Fahrenheit - Location: Olives
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36.6 Degrees Fahrenheit - Location: Cheese Shredded
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36.9 Degrees Fahrenheit - Location: Tomato Diced
Violation Issued: No

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

No orders- ensure that all spray bottles are appropriately labeled and in solid, working condition with no cracks or breaks.

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 1042241052 of 12/03/24.

Certified Food Protection Manager: Tiffany M Kuznia

Certification Number: FM99679 Expires: 04/23/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us