Electronically Delivered

September 6, 2023

Licensee
Oak Hill Assisted Living
1971 1st Avenue Northeast
Grand Rapids, MN 55744

RE: Project Number(s) SL30081015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

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

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30081	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL ASSISTED LIVING	1971 1ST AVENUE NE GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30081015-0 On August 7, 2023 through August 9, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, 20 residents were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living	0 495		

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0 495	Continued From page 2 services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 7, 2023, at 9:05 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the facility employed two licensed staff: CNS-C and licensed practical nurse (LPN)-B. CNS-C later added the facility had a "casual" RN for call, LPNs and had medical director (MD)-H as back up. The four (4) rotated call through the call forwarding system. CNS-C stated she and MD-H are on call for the LPNs. CNS-C said there is an on-call number, and "someone" is available 24 hours a day. On August 7, 2023, at 10:05 a.m., CNS-C stated she was leaving for vacation, adding she would have her phone with her, and she could answer emails. CNS-C stated the facility had a backup RN. On August 8, 2023, at approximately 7:30 a.m., the surveyor observed administrator assistant (AA)-I update MD-H of R3's blood glucose level. On August 8, 2023, at 9:35 a.m., ULP-F stated "we" (ULPs) were told if we could not reach CNS-C to call MD-H.	0 495		

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0 495	Continued From page 3 On August 8, 2023, at 9:45 a.m., ULP-M stated she had contacted MD-H "a time or two" with her (MD-H's) residents. ULP-M added, CNS-C is out on vacation, and to make it easier, she updates MD-H. On August 8, 2023, at 9:46 a.m., ULP-G stated when she called the on-call cell phone number when working afternoons, "once and a while" she spoke with MD-H. On August 8, 2023, at approximately 9:50 a.m., ULP-F pointed out to the surveyor where the on-call calendar was posted in a room used by staff. ULP-F stated the nurse's on-call phone number was listed in the phones used by staff at the facility, adding the number is posted "somewhere". ULP-F found the on-call number in the kitchen posted under the paper towel holder. ULP-F stated when she needed to talk to a nurse between 8:00 a.m. and 5:00 p.m., she "goes" to CNS-C or LPN-B adding if MD-H is "here" and CNS-C is not here, she will go to MD-H. ULP-F said "we" never know who is going to answer the on-call phone. The on-call "Yearly Calendar Template" 2023, posted noted: -orange = open/MD-H -yellow = LPN-B -green = RN-K -blue = CNS-C -purple = LPN-O July 1, 2023, through July 2, 2023: yellow July 3, 2023, through July 6, 2023: orange lines July 7, 2023, through July 9 2023: purple July 10, 2023, through July 16, 2023: green July 17, 2023, through July 23, 2023: yellow July 24, 2023, through July 30, 2023: blue	0 495		

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0 495	Continued From page 4 July 31, 2023: purple. August 1, 2023, through August 6, 2023: purple August 7, 2023, through August 13, 2023: yellow August 14, 2023, through August 20, 2023: blue August 21, 2023, through August 27, 2023: purple August 28, 2023, through August 31, 2023: green. On August 8, 2023, at 10:05 a.m., LPN-B stated if MD-H is "here" I ask her, "she is a doctor." LPN-B said MD-H would do readmission assessment if a resident came back from the hospital this day (CNS-C on vacation). LPN-B stated if the surveyor called the on-call phone number she would receive the call. On August 8, 2023, at 10:26 a.m., the surveyor interviewed AA-I regarding R3's blood glucose level. AA-I stated R3 had the Dexcom (electronic blood glucose meter) sitting on R3's phone at the table, and she saw it was "low" adding a nurse should be updated, and MD-H was the first nurse "I saw." On August 8, 2023, at 12:04 p.m., assisted living director (LALD)-A stated R12 returned to the facility last night. LALD-A said "typically" if CNS-C was not available or MD-H, they would call RN-K. LALD-A added on Tuesday MD-H is there and she would do the readmission assessment today for R12. MD-H added they don't get many late admissions. On August 8, 2023, at 2:37 p.m., the surveyor reached out to CNS-C via email communication regarding "some questions." On August 8, 2023, at 3:26 pm., CNS-C responded to the surveyor's email. "If you would	0 495		

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0 495	Continued From page 5 like to set up a time for a call, I would be happy to do that. I am still traveling with an ETA (estimated time of arrival) of 9:00 p.m. I can certainly pull over to take your call." On August 8, 2023, at 3:47 p.m., LALD-A stated "they" (facility) is designed that when the RN is not available, MD-H will cover. LALD-A said, "are you telling me we need to fire our doctor and hire another RN?" MD-H stated the statue is very clear, requiring an RN. MEDICATION R2 R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, indicated R2 required assistance with medication administration, treatments, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. On August 8, 2023, at 7:43 a.m., the surveyor observed ULP-G preparing R2's morning medication referring to R2's electronic medication administration record (EMAR). The EMAR noted to give amlodipine (heart), sertraline (depression), lisinopril (heart) but to hold diabetes medications. ULP-G took the prepared medications to R2's room. R2 asked if she should take the medications. R2 was in the process of leaving the facility to have cataract (removing cloudy lens of the eye) surgery later this day. ULP-G stated she would talk to MD-H. The surveyor observed ULP-G ask MD-H about R2's medications. MD-H told ULP-G she would speak to R2 about the medications she should take prior to surgery. ULP-G went to R2's room, R2 stated MD-H spoke	0 495		

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0 495	Continued From page 6 to her and R2 administered R2's morning medication. On August 9, 2023, at 8:58 a.m., the surveyor observed ULP-E working at a medication cart, she had a container of eye drops in her hand and was looking at the EMAR for R2. ULP-E stated, "we need a nurse here, too many questions." ULP-E stated LPN-B would not be there until after 9:00 a.m. On August 9, 2023, at 9:02 a.m., ULP-E administered R2's morning oral, nasal, and insulin medication. ULP-E said, "system not adding up with the eye drops" and "they" would need to tell the eye doctor R2's eye drops had not been given as ordered. (R2 had cataract eye surgery on August 8, 2023, and was returning to the eye doctor for a post-surgery examination). Directly after the above observation LALD-A stated he would call CNS-C. The facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated February 17, 2023, noted, RN required to be accessible to the staff 24/7. The licensee's Staffing Plan policy reviewed August 7, 2023, noted: -Procedure: two (2) licensed nurses-In house or available by phone during business hours and on call during non-business hours. On-Call registered nurse available 24/7 -Contingency Staffing: one (1) licensed nurse- In house or available by phone during business hours and on call during non-business hours. On-Call registered nurse available 24/7 -Emergency Staffing: one (1) licensed nurse- In house or available by phone during business	0 495		

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0 495	Continued From page 7 hours and on call during non-business hours. On-Call registered nurse available 24/7. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and recore review, the licensee failed to ensure reusable equipment was cleaned in-between resident use. 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).	0 510		

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0 510	Continued From page 8 The findings include: HOYER LIFT (mechanical device using a sling to assist with transfers of individuals who require support for mobility beyond the manual support provided by caregivers alone). On August 7, 2023, at 12:27 p.m., the surveyor observed unlicensed personnel (ULP)-E and ULP-M transfer R2 with a Hoyer from her Broda wheelchair ([a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) into bed. When the transfer was completed, ULP-E placed the Hoyer lift in the common's area adding the Hoyer lift will be needed in the other house to transfer R3. Directly following the above observation, the surveyor did not observe ULP-E clean the Hoyer lift. On August 7, 2023, at 12:40 p.m., ULP-E stated the Hoyer should be cleaned after each use, adding she forgot to clean the Hoyer lift. BLOOD PRESSURE MACHINE On August 8, 2023, at 1:56 p.m., the surveyor observed ULP-G take R4's blood pressure. The surveyor did not observe ULP-G clean the equipment prior or after use of the blood pressure machine. Directly after the above observation ULP-G said there were no wipes "here" while motioning to the top of the medication cart. ULP-G added she was not sure when to clean reusable equipment, but "could" wipe them down before and after use. ULP-G stated she did wipe everything down once	0 510		

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0 510	Continued From page 9 today, but she does not wipe in-between residents, each time the equipment is used. On August 9, 2023, at 9:10 a.m., clinical nurse supervisor (CNS)-C stated sharing Hoyer lifts is not "typically" done at the facility, adding she would add the cleaning of them to the policy. In addition, CNS-C said vital sign equipment was cleaned on night shift, and cleaning was not done between each resident, and maybe once a shift. adding, unless a resident is sick. The licensee's Use of Hoyer Lift policy revised October 1, 2022, noted: Lift Care: -disinfect lift surfaces -wipe with a clean towel until dry. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated August 1, 2021, noted reusable equipment and environmental surfaces would be properly disinfected after use. Whenever possible, residents would have their own reusable equipment and the equipment would not be shared with other residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 10 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of one employee (unlicensed personnel (ULP-E), and all other ULPs working at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E was hired on January 26, 2023, to provide	0 650		

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0 650	Continued From page 11 direct care services to residents of the facility. On August 7, 2023, at 12:27 p.m., the surveyor observed R2 sitting in a Broda chair (wheelchair designed to provide supportive positioning through a combination of tilt, recline, which are adjustable). ULP-M tilted R2's chair back prior to ULP-E and ULP-M using the Hoyer lift (mechanical lift using a sling) to transfer R2 from Broda chair into bed. On August 7, 2023, at 1:20 p.m., the surveyor observed ULP-E place a "hot" pack in the microwave. ULP-E stated the registered nurse (RN) taught her how to use the hot pack, adding they were R4's "personal things." We (ULPs) are to give them (packs) to her anytime she asks for them. ULP-E stated she was not sure where in the computer she would find the instructions for the hot pack use, as she was searching in R4's electronic record and was unable to find instructions for use. On August 7, 2023, at 3:14 p.m., licensed assisted living director (LALD)-A stated he spoke with clinical nurse supervisor (CNS)-C regarding documentation of training for cold packs/hot packs, tilt-n-space wheelchair (reclining) and Broda wheelchairs. LALD-A said he learned training for cold packs/hot packs, tilt-n-space wheelchair (reclining) and Broda wheelchairs was not documented for "anyone" (ULPs). On August 9, 2023, at 9:28 a.m., CNS-C stated there were no training records for any ULP for hot/cold packs, Broda, or tilt-n-space wheelchairs, however, CNS-C said she did the training with staff. The licensee's Personnel Records policy dated	0 650		

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0 650	Continued From page 12 August 1, 2021, noted the personnel record for each person would include: -record of all required training for unlicensed personnel and competency evaluations. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted when the RN or licensed heath professional instructed unlicensed staff on the resident-specific procedures on-site or verbally, the RN would document which staff received this instruction. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all 20 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 700		

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0 700	Continued From page 13 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The assisted living facility had two buildings joined together by a common's area, as part of their license (North and South buildings). NORTH HOUSE On August 8, 2023, at 7:50 a.m., the surveyor observed an opened computer screen on the top of the medication cart positioned in the commons area that consisted of a sitting area near a fireplace, dining area, open kitchen, short entry way with two offices, and a sunroom type of area. The computer screen displayed the names of residents residing in the unit and information pertaining to their care. The surveyor did not observe staff present. On August 8, 2023, at 7:53 a.m., unlicensed personnel (ULP)-G stated the computer screen was left open,"for the most part." ULP-G said, "if we feel someone is snooping, like a family member we close it". ULP-G added some people (staff) close the computer screen. On August 8, 2023, at 8:07 a.m., the surveyor observed the computer screen on top of the medication cart open, displaying medication information of the residents. There was one (1) resident sitting at the dining room table. The surveyor did not observe staff present. On August 8, 2023, at 8:25 a.m., the surveyor	0 700		

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0 700	Continued From page 14 observed the computer screen on top of the medication cart open, displaying medication information of the residents. The surveyor observed four (4) residents sitting at the dining room table in the commons area. In addition, one (1) resident and one (1) family member were in the sunroom. The surveyor did not observe staff present. On August 8, 2023, at 8:27 a.m., medical director (MD)-H stated the computer screen should not be open, displaying medication information. MD-H closed the computer screen. SOUTH HOUSE On August 9, 2023, at 7:25 a.m., the surveyor observed the computer screen on the top of the medication cart in the open position in the common's area which mirrored the North house. There were two (2) residents in electric wheelchairs positioned near the dining room table. The surveyor did not observe staff present. On August 9, 2023, at 7:39 a.m., ULP-L stated she was assigned to the medication cart. ULP-L said it was "ok" to leave the computer screen open when giving medications, adding "you don't want to hit administer to soon" adding information could be lost if the screen was closed. ULP-L added, "the big thing was to keep the medication cart locked." On August 9, 2023, at 9:10 a.m., clinical nurse supervisor (CNS)-C stated it is not "ok" to leave the computer screen open with information displayed and unattended. CNS-C added "they" (ULPs) are supposed to minimize the screen. The licensee's Confidentiality policy dated August 1, 2023, noted personal, financial, medical, or	0 700		

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0 700	Continued From page 15 other private information regarding clients or staff should not be disclosed to any other person except: -as may be required by law -to other staff as appropriate or necessary to provide services -to person authorized in writing by the client or client's responsible person to receive the information, including third party payers, or -to representatives of the commissioner authorized to survey or investigate any part of the community. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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	0 780		

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0 780	Continued From page 16 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 provide interconnected smoke alarms throughout the facility. This deficient condition had the ability to affect a limited number of 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). Findings include: On a facility tour on August 8, 2023, at approximately 10:30 a.m. with licensed assisted living director (LALD)-A it was observed that smoke alarms were not interconnected so activation of one alarm in the individual dwelling unit (north building only) activates all alarms in the individual dwelling unit (north building only). This requirement is in reference to the north building only on the north side of the fire-resistant rated wall. The south building smoke alarms on the south side of the fire-resistant rated wall are interconnected as required.	0 780		

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0 780	Continued From page 17 All smoke alarms within individual dwelling units required to have multiple alarms are required to be interconnected so activation of one alarm activates all alarms within the individual dwelling unit. This deficient finding was visually and verbally verified by LALD-A at the time of discovery. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 18 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on August 8, 2023, at approximately 10:00 a.m. of documents provided by licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. A record review of the available documentation indicated that the fire safety and evacuation map posted in egress corridors did not list room	0 810		

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0 810	Continued From page 19 locations and room numbers. The fire safety and evacuation plan map is required to include locations and number of resident rooms. It was also observed on the tour of the building the doors to the resident rooms were not labeled indicating room numbers. Resident rooms are required to be labeled with room numbers to correspond with room number identification on the fire safety and evacuation plan map. Record review of the available documentation indicated that fire protection procedures for residents in the event of a fire or similar emergency were not in the plan. Fire protection procedures and direction for residents in a fire or similar emergency are required to be included in the fire safety and evacuation plan. Documentation was provided that the residents received training verbally on an annual basis, but the training material was not available. All deficiencies were verified by LALD-A during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the	01420		

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01420	Continued From page 20 procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for the delegated tasks provided by the unlicensed personnel (ULP) for one of one resident (R3) using a Broda Chair (a wheelchair offering tilt-in-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture), and for one of one resident (R4) using cold/hot packs. 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: BRODA CHAIR R2 R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and	01420		

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01420	Continued From page 21 diabetes. R2's service plan dated November 23, 2020, indicated R2 required assistance with medication administration, treatments, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. R2's Master Care Plan dated May 30, 2023, included: -needs full help with wheelchair for mobility, uses Broda chair. On August 7, 2023, at 12:27 p.m., the surveyor observed R2 sitting in a Broda chair. ULP-M tilted R2's chair back prior to ULP-E and ULP-M using the Hoyer lift (mechanical lit using a sling) to transfer R2 from Broda chair into bed. ULP-M removed a wedge shape pillow from the Broda chair which had been positioned under R2's legs, calf area, while she was seated in the Broda chair. R2's record lacked evidence of specific written instructions for the ULP to follow regarding R2's Broda chair. On August 9, 2023, at 11:06 a.m., clinical nurse supervisor (CNS)-C stated directions for the Broda chair would have come from physical therapy (PT), adding she would have to review "that" one (entry in computer system). CNS-C said directions were not in R2's record for the Broda chair. COLD/HOT PACKS R4 R4's diagnoses included chronic shoulder pain related to arthritis.	01420		

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01420	Continued From page 22 R4's service plan dated December 22, 2021, indicated R4 required assistance with medication administration, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. R4's Master Care Plan dated July 10, 2023, included: -resident to ask staff when needing to use an ICE pack to shoulders or hips for PRN (as needed or desired) non-pharmacological treatment of pain. On August 7, 2023, at 1:20 p.m., the surveyor observed ULP-E place a "hot" pack in the microwave. ULP-E stated the RN taught them how to use them, adding they were R4's "personal things." We (ULPs) are to give them to her anytime she asks for them (packs). ULP-E stated she was not sure where in the computer she could find the instructions for their use, as she was searching in R4's electronic record. R4's record lacked evidence of specific written instructions for the ULP to follow regarding R4's cold/hot packs. On August 9, 2023, at 9:14 a.m., CNS-C stated R4's record did not include instructions for ULPs regarding cold/hot packs, adding she would add instructions. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted the RN developed written specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01420		

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01420	Continued From page 23 (21) days	01420		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing	01470		

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01470	Continued From page 24 services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one employee's, (unlicensed personnel (ULP)-E) employee record contained orientation to assisted living facility licensing to include all the required topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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:	01470		

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	30081	A. BUILDING: _____ B. WING _____	08/09/2023

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01470	Continued From page 25 ULP-E was hired on January 26, 2023, to provide direct care services to residents of the facility. On August 7, 2023, at 12:27 p.m., the surveyor observed ULP-E and ULP-M transfer R2 from a Broda chair (a wheelchair offering tilt-in-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) into bed using a Hoyer lift (mechanical lift that uses a sling). ULP-E's employee record included: -MN-Statute-CHAPTER-144G-ASSISTED LIVING, 0.25 hours, completed on January 31, 2023. ULP-E's employee record lacked evidence of completing the following assisted living orientation before providing assisted living services to the licensee's residents: - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On August 7, 2023, at approximately 4:20 p.m., licensed assisted living director (LALD)-A stated the facility had not reviewed the scope of what the licensee does with any of their staff. LALD-A said the class assigned to all staff (listed above) is "more of a general review of 144.G." LALD-A added reviewing their Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) would be done in the future. The licensee's Assisted Living Orientation- All Staff policy dated August 1, 2021, noted the orientation would contain: - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living	01470		

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01470	Continued From page 26 Services and amenities and providers scope of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	Continued From page 27 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received a total of eight (8) hours of annual training each 12 months of employment, to include all required content for three of three employees (clinical nurse supervisor (CNS)-C, registered nurse (RN)-K, unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500		

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01500	Continued From page 28 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: CNS-C CNS-C was hired on October 25, 2004, to provide supervision of staff and direct care services to the residents. On August 7, 2023, at 9:05 a.m., during the entrance conference, CNS-C stated she was the primary nurse for the facility and identified herself as the CNS. CNS-C stated she worked Monday through Friday from 7:00 a.m. until 3:00 p.m. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -affective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. CNS-C had completed a total of four (4) hours of annual training.	01500		

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01500	Continued From page 29 RN-K RN-K was hired on October 1, 2017, to provide supervision of staff and direct care services to the residents. RN-K s employee record lacked evidence RN-K successfully completed annual training as required to include: -affective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. RN-K had completed a total of six (6) and a half hour of annual training. On August 8, 2023, at 4:05 p.m., licensed assisted living director (LALD)-A stated CNS-C and RN-K did not have the required eight (8) hours of annual training. ULP-G ULP-G was hired on July 27, 2020, to provide direct care services to residents of the facility. On August 8, 2023, at 7:43 a.m., the surveyor observed ULP-G prepare and administer R2's morning medication. ULP-G's employee record lacked evidence ULP-G successfully completed annual training as required to include:	01500		

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01500	Continued From page 30 -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the assisted living bill of rights and staff responsibility's related to assuring the exercise and protection of those rights -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques, the need for and use of protective gloves, gowns, and masks: appropriate disposal of contaminated materials and equipment, such as dressing, needles, syringes, and razor blades, disinfecting reusable equipment, disinfecting environmental surfaces, and reporting communicable diseases -affective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On August 9, 2023, at 8:22 a.m., LALD-A stated ULP-G did not have the required annual training. ULP-G's training record was requested, however LALD-A said ULP-G had not done any annual training. LALD-A added he can't get staff to do their required annual training. The licensee's Annual Training, All Staff policy dated August 1, 2021, noted all assisted living employees would complete annual education on the following topics: -reporting of maltreatment of vulnerable adults	01500		

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01500	Continued From page 31 under section 626.557 -assisted living bill of (sic) rights -staff responsibility related to ensuring the exercise and protecting in the assisted living bill of rights -infection control techniques used in the home and implementation of infection control standards including: i. hand washing ii. need for and use of protective gloves, gowns, and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. disinfecting reusable equipment v. disinfecting environmental surfaces vi. reporting communicable diseases -effective approaches for problem solving when working with challenging behaviors -effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders -review of policies and procedures related to the provision of assisted living services and how to implement them -principles of person-centered planning and service delivery -how person-centered planning and service delivery applies to direct support services proved by staff -emergency and disaster training. Annual training would be documented in accordance with the documentation policy. In addition, direct-care staff would complete 8 hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01500		

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01500	Continued From page 32 (21) days	01500		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees, (unlicensed personnel (ULP)-E, ULP-J) received the required amount of dementia care training in the required time frame.	01530		

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01530	Continued From page 33 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on January 26, 2023, to provide direct care services to residents of the facility. On August 7, 2023, at 12:27 p.m., the surveyor observed ULP-E and ULP-M transfer R2 from a Broda chair (a wheelchair offering tilt-in-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) into bed using a Hoyer lift (mechanical lift that used a sling). ULP-E's employee record included: -Preventing Adverse Reactions to Dementia Care, 0.5 hours, completed March 20, 2023 -Changing the Culture to Person-Centered Care, 0.5 hours, completed April 14, 2023. ULP-E's employee record did not include a total of eight hours of the required dementia training completed within 160 hours of the employee's start date. On August 7, 2023, at 4:14 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have the required dementia training	01530		

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01530	Continued From page 34 completed. LALD-A added he had been "harping" on her to complete the required training. LALD-A verified ULP-E had worked over 160 hours at the facility. ULP-J ULP-J was hired on February 15, 2023, to provide direct care services to residents of the facility. ULP-Js employee record included: -About Alzheimer's disease and Dementia, 1 hour, completed July 15, 2023. ULP-J's employee record did not include a total of eight hours of the required dementia training completed within 160 hours of the employee's start date. On August 7, 2023, at 4:42 p.m., LALD-A stated ULP-J did not have the required dementia training completed. The licensee's Dementia Training Disclosure undated document noted direct-care staff would complete: -a minimum of eight (8) hours of initial training on dementia care topic -initial training would be completed within 160 working hours of the employment start date. Dementia care training would include: -an explanation of Alzheimer's disease and other dementia's -assistance with activities of daily living -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01530		

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01530	Continued From page 35 (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool with a change of condition for one of two residents (R12).	01620		

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01620	Continued From page 36 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: R12's diagnoses included Parkinson's disease (disorder of the central nervous system that effects movement), diabetes, depression, dementia, arthritis, and anxiety. R12's service plan dated June 16, 2020, indicated R12 received the following services: -medication administration, blood sugar monitoring, bathing assist, hygiene/grooming, dressing, mobility assist, toileting/continence assist. On August 7, 2023, at approximately 9:45 a.m., licensed assisted living director (LALD)-A stated during the entrance conference one resident (R12) was currently in the hospital. On August 8, 2023, at 12:03 p.m., LALD-A stated R12 had returned from the hospital "last night." LALD-A added "they" (facility) had 24 hours to complete a readmission assessment. On August 9, 2023, at 10:55 a.m., the surveyor observed licensed practical nurse (LPN)-B and unlicensed personnel (ULP)-E reposition R12 in bed. R12's service plan undated, printed "as of August	01620		

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01620	Continued From page 37 8, 2023," noted resident reassessment and monitoring would be conducted by the registered nurse no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. An assisted living facility would conduct a nursing assessment during the weekend for a resident who was ready to be discharged from the hospital and return to the facility. R12's clinical update assessment was completed on August 8, 2023, by medical director (MD)-H. On August 9, 2023, at 9:22 a.m., clinical nurse supervisor (CNS)-C stated MD-H would do reassessments as needed, adding "I had a vacation that was scheduled." CNS-S stated the "other" RN had another job, adding the other RN just does call for us in the evenings, and MD-H covers for vacation. The licensee's Initial and On-going Nursing Assessment of Residents policy dated August 1, 2021, noted nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 38 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of four residents (R2, R8, R4) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01640		

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01640	Continued From page 39 The findings include: R2 R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, indicated R2 required assistance with medication administration, treatments, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. Brace - R2 On August 8, 2023, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-M remove a blue foam block from R2's right hand. ULP-M washed the inside of R2's hand. ULP-M stated she was not sure of the name of the blue foam block, "foam piece". ULP-M added R2 hated the brace and clinical nurse supervisor (CNS)-C and medical director (MD)-H came up with it, "something that would spread her hand apart. On August 8, 2023, at 7:29 a.m., the surveyor observed ULP-M place the blue foam block back in R2's right hand. R2's service recap summary dated August 1, 2023, through August 8, 2023, included: -brace management. Blood Glucose - R2 On August 7, 2023, at 11:56 a.m., ULP-F stated she had checked R2's Dexcom (system that tracks blood glucose levels continuously through the day and night) and the reading was 159. R2's prescriber's order dated July 13, 2023, included record blood glucose four (4) times daily:	01640		

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01640	Continued From page 40 8:00 am., 11:30 a.m., 4:40 p.m., 8:00 p.m. Wound Care - R2 On August 8, 2023, at 7:43 a.m., the surveyor observed medical director (MD)-H changing R2's dressing on right foot. R2's treatment plan included wound care, dated July 11, 2023, LPN (licensed practical nurse), cleanse right heel wound with wound cleanser. Apply Hydrogel (wound cleaner/hydrator) to wound bed followed by dry gauze in wound bed and covered with Alevyn (dressing). Secure with Kerlix (wrap) as needed. R2's service plan was not revised to include current services provided. On August 8, 2023, at 1:44 p.m., licensed assisted living director (LALD)-A stated R2's service plan was not revised when they went to the new system and was missing treatment information: wound care, brace, and blood glucose monitoring. R8 R8's diagnoses included chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, hypertension (HTN-high blood pressure), and anxiety. R8's service plan dated May 2, 2022, indicated R8 received services including bathing, dressing, escort/mobility assistance, grooming, medication administration, blood glucose three days a week, transfer assistance, and pulse monitoring daily. On August 8, 2023, at approximately 8:45 a.m.,	01640		

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01640	Continued From page 41 the surveyor observed ULP-G monitor R8's blood glucose. ULP-G assisted R8 to the bathroom with use of a walker. The surveyor observed ULP-G move a pressure pad type of alarm from R8's bed and place the pressure alarm into R8's wheelchair. R8's service plan was not revised to include current services provided. On August 8, 2023, at 3:32 p.m., LALD-A stated R8's service plan was not updated as required, adding they did not "think" an alarm would be needed at first for R8 but later added alarm. R4 R4's diagnoses included chronic shoulder pain related to arthritis. R4's service plan dated December 22, 2021, indicated R4 required assistance with medication administration, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. On August 7, 2023, at 1:20 p.m., the surveyor observed ULP-E place a "hot" pack in the microwave. ULP-E stated the RN taught them how to use them, adding they are R4's "personal things" we are to give them to her anytime she asks for them. ULP-E stated she was not sure where in the computer where to find the instructions for their use, as she was searching in R4's electronic record. R4's service plan was not revised to include current services provided. On August 8, 2023, at 4:42 p.m., LALD-A stated R4's service plan was not revised to include	01640		

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01640	Continued From page 42 ice/hot packs, adding the cold/hot packs were added after R4 got there. LALD said he thought he saw something about warm packs on R4's care plan. On August 9, 2023, at 9:28 a.m., CNS-C stated service plans should have been revised to include current services provided. The licensee's Contents of Service Plans policy dated August 1, 2021, noted all assisted living residents have an up-to date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the	01650		

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01650	Continued From page 43 facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2). 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: R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, indicated R2 required assistance with medication	01650		

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01650	Continued From page 44 administration, treatments, bathing, hygiene/grooming, dressing, mobility, toileting, laundry and housekeeping services. On August 8, 2023, at 7:22 a.m., the surveyor observed R2 sitting in a Broda chair (a wheelchair offering tilt-in-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) and unlicensed personnel (ULP)-G and ULP-M were assisting R2 with morning cares. R2's service plan lacked the following required content: -the methods of monitoring assessments of residents -the frequency for treatments -the frequency for mobility -the frequency for medication administration -the frequency for toileting/continence assistance On August 8, 2023, at approximately 1:10 p.m., licensed assisted living director (LALD)-A stated "about" 70% of service plans had been updated using their new system. On August 8, 2023, at 1:44 p.m., LALD-A stated R2's service plan was not updated to include the frequency of toileting, mobility assist, and the method for resident assessments. LALD-A stated R2's service plan was also missing frequency for the treatment's provided: wound care, blood glucose monitoring, brace application. The licensee's Contents of Service Plans policy dated August 1, 2021, noted service plans included: -a description of the services provided -fees for services -frequency of each service according to resident	01650		

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01650	Continued From page 45 assessment and resident preferences -schedule and methods of monitoring assessment -schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R8, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01750		

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01750	Continued From page 46 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: R8 R8's diagnoses included chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), diabetes, hypertension (HTN-high blood pressure), and anxiety. R8's service plan dated May 2, 2022, included medication administration. TOPICAL MEDICATION R8's August 1, 2023, through August 7, 2023, medication administration record (MAR) included Trolamine "Cre" cream 10% (pain reliever) (daily) apply topically to affected area(s) twice daily. On August 8, 2023, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-G apply gloves and ask R8 where she would like the cream applied. R8 was seated in a wheelchair rubbing her hands together. ULP-G asked, would you like it on your shoulders? R8 stated no. ULP-G asked, would you like it on your knees? R8 stated yes. ULP-G applied the cream to R8's knees. INHALER R8's August 1, 2023, through August 7, 2023, medication administration record (MAR) included	01750		

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01750	Continued From page 47 Advair 250-50 Disk daily, inhale one (1) puff by mouth two (2) times a day. On August 8, 2023, at 8:55 a.m., the surveyor observed ULP-G administer R8's Advair inhaler. ULP had a basin and water near and instructed R8 to rinse her mouth with the water and to spit into the basin. Directly following the above observation ULP-G stated R8's MAR did not include to have R8 rinse her mouth out with water after inhalation, but she had been trained to do it (administration) that way "somewhere." ULP-G stated she could not remember if she learned it at this facility or at a different facility. On August 9, 2023, at 9:27 a.m. clinical nurse supervisor (CNS)-C stated R8's record did not include specific directions for ULPs to follow for R8's cream, adding it is to go on R8's hands. CNS-C stated R8's record did not include specific directions for R8's Advair inhaler. The manufacturer's direction for Advair Diskus inhaler dated December 2021, noted rinse your mouth with water without swallowing after using Advair to help reduce your chance of getting thrush. R3 R3's diagnoses included cellulitis of right lower limb (skin infection) diabetes, and acquired absence of left leg below the knee. R3's service plan dated July 12, 2023, indicated R3 required assistance with medication administration. On August 7, 2023, at approximately 11:30 a.m.,	01750		

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01750	Continued From page 48 the surveyor observed ULP-F administer an oral medication to R3. R3's August 1, 2023, through August 7, 2023, MAR included: -triamcinolone 0.1 % cream, apply to skin topically two times per day for itchy skin. R3's MAR did not include specific instructions for the ULPs to include where to apply triamcinolone cream. On August 9, 2023, at 9:29 a.m., CNS-C stated R3's MAR did not include instructions for ULPs of where to place R3's triamcinolone cream. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted RN had developed specific written instructions for each resident and documented those instructions in the resident's medication record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

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01760	Continued From page 49 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medication was given per manufacturer's instructions for one of three residents (R3). In addition, the licensee failed to ensure the steps of the medication administration process was followed for two of four unlicensed personnel (ULP-M, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: MANUFACTURER'S INSTRUCTION R3 R3's diagnoses included cellulitis of right lower limb (skin infection) diabetes and acquired absence of left leg below the knee. R3's service plan dated July 12, 2023, indicated R3 required medication administration. On August 7, 2023, at 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-F with	01760		

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01760	Continued From page 50 gloved hands prepare R3's insulin pen. ULP-F removed the cap of R3's Novolog insulin pen. ULP-F attached the needle to the pen and primed the pen with two (2) units of insulin. ULP-F dialed the pen to 6 units and cleaned R3's right upper arm with an alcohol pad and injected the insulin in R3's upper right arm. ULP-F was not observed to clean the top of the insulin pen with an alcohol wipe prior to attaching the needle. R3's provider's order dated July 14, 2023, included: Novolog FlexPen 100 units/milliter, 6 units subcutaneous (under skin) 7:30 a.m., 11:30 a.m., 4:30 p.m., 8:00 p.m. Directly following the above observation ULP-F stated, "yes, yes, yes", I forgot to clean the pen prior to applying the needle. The manufacturer's instructions for Novolog pens dated January 1, 2019, noted wipe the pen tip with an alcohol pad, remove the seal on the needle cap and twist or push the needle straight onto the pen tip. On August 9, 2023, at 9:10 a.m., CNS-C stated ULPs were to clean insulin pens prior to applying the needle, adding it is in their policy. The licensee's Insulin Pen policy dated April 13, 2021, noted to clean tip of pen with alcohol swab. DOCUMENTATION OF MEDICATION ADMINISTRATION ULP-M On August 7, 2023, at 12:27 p.m., the surveyor observed ULP-M apply Nyamyc (nystatin /yeast) powder under R2's abdomen folds and under R2's left breast.	01760		

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01760	Continued From page 51 On August 8, 2023, at 7:22 a.m., the surveyor observed ULP-G and ULP-M assisting R2 with morning cares. ULP-M applied nystatin powder under R2's right breast. The surveyor did not observe ULP-M document the application of nystatin powder in R2's record. R2's August 1, 2023, through August 7, 2023, medication administration record (MAR) included: -nystatin 100,000 units (u)/gram (gm) powder apply topically to affected area(s) twice daily as needed (PRN) R2's August 1, 2023, through August 7, 2023, MAR did not contain any documentation of R2's nystatin powder. On August 9, 2023, at 9:21 am., clinical nurse supervisor (CNS)-C stated ULPs should be documenting when PRN nystatin powder is applied. TIMELY MEDICATION DOCUMENTATION ULP-G On August 8, 2023, at 8:10 a.m., the surveyor observed ULP-G administer R11's morning medication with a glass of prune juice at the dining room table. The surveyor did not observe ULP-G document R11's medications had been administered. On August 8, 2023, at 8:26 a.m., ULP-G stated she "hit" administered as she was preparing R11's medication, prior to administering R11's morning medication. On August 9, 2023, at 9:10 a.m., CNS-C stated ULPs were to document after medications were given.	01760		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 52 The license's Medication Administration-Documentation policy dated May 25, 2017, noted documentation of medication reminder, medication assistance or medication administration would be completed immediately after that task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures. In addition, the licensee failed to ensure the medication cart was secured in one of two buildings (north house). Further, the licensee failed to ensure medication was secured in a locked area for one of three residents (R2). 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	01880		

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	30081	A. BUILDING: _____ B. WING _____	08/09/2023

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01880	Continued From page 53 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The assisted living facility had two (2) buildings joined together by a common's area, as part of their license (North and South buildings). MEDICATION STORED ACCORDING TO MANUFACTURERS' RECOMMENDATIONS On August 7, 2023, at 11:08 a.m., the surveyor and licensed practical nurse (LPN)-B reviewed the contents of the medication refrigerator. LPN-B stated the current temperature of the medication refrigerator was 38.8 degrees Fahrenheit (F). The surveyor requested the medication refrigerator log. LPN-B asked house coordinator (HC)-P for the temperature log. HC-P stated she did not monitor the medication refrigerator. LPN-B looked in the facility's on-line system through "tasks" to find out who monitored the medication refrigerator. LPN-B could not locate the task of medication refrigerator monitoring. LPN-B asked facility director (FD)-D about the medication refrigerator log. On August 7, 2023, at 11:14 a.m., FD-D stated the medication refrigerator should be between 32 and 40 degrees F. He said he got alerts when the temperature was outside of that range. On August 7, 2023, at approximately 12:10 p.m., the medication refrigerator log was reviewed with FD-D. FD-D stated several times the temperature was outside of the 36-46 F degree range. FD-D asked if "all medications" needed to be kept within this range. FD-D added the refrigerator temperatures were recorded hourly.	01880		

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01880	Continued From page 54 On August 7, 2023, at approximately 12:20 p.m., LPN-B observed the medication refrigerator and confirmed the following contents: -4 Basaglar 100 units/ milliliter (ml) (long-acting) unopened insulin pens for R3 -11 Novolog (short-acting) unopened insulin pens for R3 -8 Lantus 100 units/ml (long-acting) unopened insulin pens for R8 -6 Humalog Kwik 100 units/ml (short acting) unopened insulin pens for R2 -5 Lantus 100 units/ml unopened insulin pens for R2 -14 Humalog Kwik 100 units/ml unopened insulin for R9 -7 Lantus 100 units/ml unopened insulin pens for R9 The refrigerator temperature log recap (average daily temperature) sheet dated July 1, 2023, through August 7, 2023, indicated the following: -the temperature was recorded 38 out of 38 opportunities -5 out of the 38 opportunities the daily average temperature was out of range and documented below 36 degrees F -hourly recording below 36 degrees F ranging as low as 33.4 degrees F. The manufacturer's instructions for Basaglar insulin dated July 2021, indicated to store unopened Basaglar insulin in the refrigerator between 36-46 degrees F. Do not allow Basaglar to freeze. The manufacturer's instructions for Novolog insulin dated January 2019, indicated to store unopened Novolog in a refrigerator between 36-46 degrees F. Do not allow Novolog to freeze.	01880		

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01880	Continued From page 55 The manufacturer's instructions for Lantus insulin dated March 2020, indicated to store unopened Lantus in a refrigerator between 36-46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions Humalog insulin dated April 2020, indicated to store unopened Humalog in a refrigerator between 36-46 degrees F. Do not allow Humalog to freeze. SECURE MEDICATION CART, NORTH HOUSE On August 8, 2023, at 8:25 a.m., the surveyor observed the medication cart unlocked and positioned in the open commons area (an area that consisted of a sitting area near a fireplace, a dining area, open kitchen, short entry way with two offices, and a sunroom). The surveyor observed four (4) residents sitting at the dining room table in the commons area. In addition, one (1) resident and one (1) family member were positioned in the sunroom. The surveyor did not observe a staff member within eyesight of the unlocked medication cart. On August 8, 2023, at 8:27 a.m., medical director (MD)-H walked through the common's area in the north building. MD-H stated the medication cart should be locked. MD-H locked the medication cart. SECURE MEDICATION STORAGE R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, indicated R2 required assistance with medication administration.	01880		

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01880	Continued From page 56 R2's assessment dated May 30, 2023, noted: -needs full medication management and setup -secure storage of medications: centrally stored medications are locked, and medications are administered each shift by a single staff person. On August 8, 2023, at 12:27 p.m., the surveyor observed two (2) partial containers of Nyamyc powder (nystatin-yeast) in R2's room. The surveyor observed ULP-M apply Nyamyc powder under R2's abdomen folds and under R2's left breast. On August 9, 2023, at 9:21 am., clinical nurse supervisor (CNS)-C stated R2's nystatin powder should be in the locked medication cart and not left in R2's room. The licensee's Storage of Medication policy dated August 1, 2021, noted the RN (registered nurse) would develop an individualized medication management plan for the resident that would address storage of the resident's medications. The RN would recommend where medication should be stored understanding that our agency may not be able to control where and how a resent stores his/her medications in their room. The RN would provide education to the resident/residents' representative on proper storage of medication in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendation. This may include a combination of the resident's room and the nursing office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 57	01890		
01890 SS=F	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 bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two medication carts (North and South). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The assisted living facility had two (2) buildings joined together by a common's area, as part of their license (North and South buildings). SOUTH MEDICATION CART On August 7, 2023, at 10:41 a.m., the surveyor and unlicensed personnel (ULP)-F reviewed the contents of the locked medication cart. ULP-G observed and confirmed the following:	01890		

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01890	Continued From page 58 -R3's opened Basaglar 100 units/milliliter (ml) insulin pen (long-acting insulin) did not have a label which indicated the date the insulin had been opened and when the insulin would expire. -R6's opened brimonidine-timolol 0.2% (high eye pressure) eye solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire. -R6's two (2) opened latanoprost .0005% (high eye pressure) eye solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire. -R7's opened polyvinyl (dry eyes) solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire. On August 7, 2023, at 10:44 a.m., ULP-F stated the above medication should be dated, adding, "especially" if the medication has a label attached to write dates on (the above medications had labels attached to write the dates on.) NORTH MEDICATION CART On August 7, 2023, at approximately 10:50 a.m., the surveyor and licensed practical nurse (LPN)-B reviewed the contents of the locked medication cart. LPN-B observed and confirmed the following: -R8's opened Advair Diskus did not have a label which indicated the date the Advair had been opened and when it would expire -R8's opened Lantus 100 units/ml (long-acting) insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire. -R4's opened polyvinyl eye solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire.	01890		

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01890	Continued From page 59 -R2's opened Humalog 100 units/ml (short acting) insulin pen had "7/29" written on the label, however, insulin pen did not have a label which indicated the complete date the insulin had been opened and when the insulin would expire -R2's opened Lantus 100 units/ml insulin pen had "7/26" written on the label, however, insulin pen did not have a label which indicated the complete date the insulin had been opened and when the insulin would expire. -R9's opened Lantus 100 units/ml insulin pen insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire -R9's opened Humalog 100 units/ml insulin pen insulin pen did not have a label which indicated the date the insulin had been opened and when the insulin would expire. -R10's opened Refresh (dry eyes) 5 milligrams (mg)/ml solution did not have a label which indicated the date the eye solution had been opened and when the solution would expire. Directly following the above observation LPN-B stated, "these girls need to be marking when open." LPN-B said the above listed medications should have been dated, with complete dates, when opened. On August 9, 2023, at approximately 9:15 a.m., clinical nurse supervisor (CNS)-C stated inhalers, eye drops, insulin pens should be dated. The manufacturer's instructions for Basaglar insulin dated June 4, 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for brimonidine-timolol dated December 7, 2021,	01890		

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01890	Continued From page 60 directed eye drops can be stored for four weeks once the bottle has been opened. Even if there is still some solution remaining after this time, discard. The manufacturer's instructions for latanoprost dated February 20, 2023, directed to discard within 4 weeks of opening. The manufacturer's instructions for polyvinyl eye drops dated 2023, directed once the product was opened, most experts recommend discarding the product after 30 days. The manufacturer's instructions for Lantus insulin dated June 4, 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Humalog insulin dated June 4, 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Refresh eye drops dated September 23, 2016, directed do not use more than 30 days after first opening. The licensee's Storage of Medication policy dated August 1, 2021, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, the resident' name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided.	01890		

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01890	Continued From page 61 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, and interview the licensee failed to ensure a prescription medication supply for one resident was not being used by another, other than the resident prescribed for one of one resident (R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 8, 2023, at approximately 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare R13's morning medication. ULP-G removed acetaminophen 1000 milligrams (mg), citalopram (depression) 10 mg, lisinopril (heart) 5 mg, multi-vitamin, a container of Reguloid Orange (constipation) and a vial of Refresh single use eye drop. The Reguloid ULP-G removed from the medication cart was	01900		

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01900	Continued From page 62 from the bottom drawer of the medication cart with R8's initials written on the top of the container with a black marker. ULP-G placed the correct amount of Reguloid in a medication cup and took it to the kitchen area where she mixed the medication with water. On August 8, 2023, at 8:25 a.m., the surveyor asked ULP-G to return to the medication cart to double check R13's Reguloid medication. ULP-G opened the first and second drawer of the medication cart before looking in the bottom drawer. ULP-G saw the other resident's initials (R8) on the Reguloid container and stated, "it is the same medication." Directly after the above observation ULP-G wasted the Reguloid medication she had prepared for R13. ULP-G prepared R13's Reguloid medication from the container with R13's name and prescription on the label. On August 9, 2023, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated it was not "ok" to use one resident's medication for another resident. CNS-C said the procedure was, when something (medication) was getting low "they" (ULP) let a nurse know and the medication was reordered. The licensee's Medication Administration-Licensed Nursing and ULP's policy dated September 2020, noted follow the "6 rights" - right person, right medication, right time, right route (i.e. by mouth, eye drops, to the skin), right dose (i.e. how many milligrams, drops), right chart/record to document the medication was taken. Compare the information on the medication administration record with the label on the medication container. The following information	01900		

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01900	Continued From page 63 should be in all places: individual client's name, name of medication, strength and dosage of medication, route, time that the medication should be given, any special instructions. Read the label and compare it with the information on the MAR there times to make sure that you have not made a mistake. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 64 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 7, 2023, at approximately 9:25 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment services to residents. R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's Master Care Plan dated May 30, 2023, included:	01940		

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01940	Continued From page 65 -hand brace to be worn on right hand related to contractures. Resident frequently refuses to wear brace. Foam placed in hand as alternative when resident refused brace. R2's prescriber's order dated July 15, 2023, included: -brace management: twice daily, 7:00 a.m., 11:00 a.m. assist with putting brace on/off. Specific instructions: place brace onto right extremity in the morning when resident gets up for the day. Remove after 4-6 hours. Notify RN if: skin under brace becomes itchy for resident or resident refuses. R2's service plan dated November 23, 2020, lacked a written statement of the treatment services the resident received to include brace management/foam block use. R2's record lacked evidence of an individualized treatment or therapy management plan which included the following: - a statement of the type of services that would be provided - identification of treatment or therapy tasks that will be delegated to unlicensed personnel (ULP) - any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 8, 2023, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-M remove a blue block from R2's right hand. ULP-M washed R2's right hand and checked R2's skin under her breasts. ULP-M stated she was not sure what the foam was, and not sure of the name of it, "foam piece". ULP-M added R2 hated the brace and	01940		

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OAK HILL ASSISTED LIVING	1971 1ST AVENUE NE GRAND RAPIDS, MN 55744

(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
01940	Continued From page 66 CNS-C and medical director (MD)-H came up with it (blue foam), "something that would spread her hand apart." On August 8, 2023, at approximately 1:10 p.m., licensed assisted living director (LALD)-A stated R2's service plan had not been updated as required adding, "about" 70% of service plans had been updated using their new system. On August 9, 2023, at approximately 9:20 a.m., CNS-C stated she had seen R2's blue foam block. CNS-C stated R2 was supposed to be wearing the brace, adding she is aware R2 would often refuse the brace. CNS-C added the brace was on R2's services. CNS-C stated ULP's should be documenting R2 refusing the brace. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted treatments or therapy tasks may be delegated or assigned by a licensed health professional to unlicensed personnel according to the licensed health professional's applicable licensing practice standards. When a treatment or therapy was delegated or assigned to unlicensed personnel, the RN or authorized licensed health professional must: -develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes 144.4793, subd. 3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30081	A. BUILDING: _____ B. WING _____	08/09/2023

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01950	Continued From page 67	01950		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R3, R2). 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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30081	A. BUILDING: _____ B. WING _____	08/09/2023

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OAK HILL ASSISTED LIVING	1971 1ST AVENUE NE GRAND RAPIDS, MN 55744

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01950	Continued From page 68 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's diagnoses included cellulitis of right lower limb (skin infection) diabetes and acquired absence of left leg below the knee. R3's service plan dated July 12, 2023, indicated R3 required assistance with bed mobility, denture care, dressing, glasses, grooming, Hoyer lift transfer (mechanical lift using a sling), medication administration, blood glucose monitoring, and skin treatments, two (2). On August 7, 2023, at 11:56 a.m., the surveyor observed unlicensed personnel (ULP)-N and ULP-F assisting R3 into bed. ULP-F removed a foam boot from R3's right leg and a brace from R3's left leg stump. R3's prescriber's order dated July 14, 2023, included: -compression stockings: change compression stocking sleeve to left leg stump daily every morning. Rinse current compression sleeve with warm water and hang to dry. Monitor and report to RN skin irritation, increased swelling, difficulty putting on, marks on skin and refusal to wear. R3's Master Care Plan dated July 26, 2023, included: -foam boot to right foot/leg when up in wheelchair -needs help with anti-embolism/compression stocking- on and off, compression sock on left leg to keep molded to fit prosthetic. R3's record lacked evidence of specific written	01950		

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	30081	A. BUILDING: _____ B. WING _____	08/09/2023

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OAK HILL ASSISTED LIVING	1971 1ST AVENUE NE GRAND RAPIDS, MN 55744

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01950	Continued From page 69 instructions for the ULP to follow regarding complete instructions for R3's left leg brace and R3's foam boot. On August 9, 2023, at 9:31 a.m., clinical nurse supervisor (CNS)-C stated the "long brace" had been a question, back and forth with therapy, "honestly if not on there (record) it is an over site." On August 9, 2023, at 11:05 a.m., CNS-C stated R3's record did not include directions for R3's leg brace, adding direction would have come from physical therapy (PT). R2 R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, did not include R2's brace. R2's Master are Plan dated May 30, 2023, included: -hand brace to be worn on right hand related to contractures. Resident frequently refuses to wear brace. Foam placed in hand as alternative when resident refused brace. R2's prescriber's order dated July 15, 2023, include: -brace management: twice daily, 7:00 a.m., 11:00 a.m. assist with putting brace on/off. Specific instructions: place brace onto right extremity in the morning when resident gets up for the day. Remove after 4-6 hours. Notify RN if: skin under brace becomes itchy for resident or resident refuses. On August 8, 2023, at 7:22 a.m., the surveyor	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 70 observed ULP-M remove a blue block from R2's right hand. ULP-M washed R2's right hand and checked R2's skin under her breasts. ULP-M stated she was not sure that the foam was, not sure of the name, "foam piece". ULP-M added R2 hated the brace and CNS-C and medical director (MD)-H came up with it, "something that would spread her hand apart." On August 9, 2023, at 7:29 a.m., the surveyor observed ULP-M place the blue foam block into R2's right hand. R2's Service Recap Summary dated August 1, 2023, through August 8, 2023, included: brace management 7:00 a.m., 11:00 a.m. On August 9, 2023, at approximately 9:20 a.m., CNS-C stated had seen R2's blue foam block. CNS-C stated R2 is supposed to be wearing the brace, adding she is aware R2 would often refuse the brace. CNS-C stated she is not sure if the directions came from MD-H, adding if there are no directions for the foam, it should not be used. CNS-C confirmed R2's record did not contain specific instructions for the blue foam ULPs were using on R2's right hand. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted a register nurse may delegate nursing services, or an authorized Licensed Health Professional my delegate treatments or assign therapy tasks, to unlicensed personnel after: -completing a nursing assessment of the resident functional status and need for nursing services -developing a service plan for providing the services according to the to resident's needs and preferences -determining that the unlicensed person is trained	01950		

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01950	Continued From page 71 and competent and has been instructed in the proper methods to perform the procedures with respect to the specific resident -included written instructions for performing the procedure for the resident in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of two residents (R2). 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	01960		

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01960	Continued From page 72 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included right hemiparesis (muscle weakness or partial paralysis) and diabetes. R2's service plan dated November 23, 2020, did not include R2's brace. R2's Master Care Plan dated May 30, 2023, included: -hand brace to be worn on right hand related to contractures. Resident frequently refuses to wear brace. Foam placed in hand as alternative when resident refused brace. R2's prescriber's order dated July 15, 2023, included: -brace management: twice daily, 7:00 a.m., 11:00 a.m. assist with putting brace on/off. Specific instructions: place brace onto right extremity in the morning when resident gets up for the day. Remove after 4-6 hours. Notify RN if: skin under brace becomes itchy for resident or resident refuses. On August 8, 2023, at 7:22 a.m., the surveyor observed unlicensed personnel (ULP)-M remove a blue block from R2's right hand. ULP-M washed R2's right hand and checked R2's skin under her breasts. ULP-M stated she was not sure what the foam was, and not sure of the name of it, "foam piece". ULP-M added R2 hated the brace and clinical nurse supervisor (CNS)-C and medical	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 73 director (MD)-H came up with it (blue foam), "something that would spread her hand apart." On August 9, 2023, at 7:29 a.m., the surveyor observed ULP-M place the blue foam block into R2's right hand. R2's Service Recap Summary dated August 1, 2023, through August 8, 2023, included: brace management 7:00 a.m. seven (7) of seven (7) opportunities, documented as completed. brace management 11:00 a.m. seven (7) of seven (7) opportunities, documented as completed. R2's record did not include documentation of brace refusal, nor did it include documentation of the blue foam block. On August 9, 2023, at approximately 9:20 a.m., CNS-C stated she had seen R2's blue foam block. CNS-C stated R2 was supposed to be wearing the brace, adding she is aware R2 would often refuse the brace. CNS-C added the brace was on R2's services. CNS-C stated ULP's should be documenting R2 refusing the brace. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted treatments or therapy tasks may be delegated or assigned by a licensed health professional to unlicensed personnel according to the licensed health professional's applicable licensing practice standards. When a treatment or therapy was delegated or assigned to unlicensed personnel, the RN or authorized licensed health professional must: -develop and maintain a current individualized treatment or therapy management record for	01960		

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01960	Continued From page 74 each resident that addresses the requirements of MN Statutes 144.4793, subd. 3. In addition, the licensee would instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the unlicensed personnel had demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/07/23*
Time: 12:00:02
Report: 7939231128

Food and Beverage Establishment Inspection Report

Location:
Oak Hill Assisted Living
1971 1st Avenue Ne
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0038133
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189999057
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

ORDER ISSUED FOR INFORMATIONAL PURPOSE

Comply By: 08/08/23

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: COTTAGE CHEESE
Temperature: 41 Degrees Fahrenheit - Location: NORTH KITCHEN FRIDGE
Violation Issued: No

Process/Item: CHEESY POTATO
Temperature: 39 Degrees Fahrenheit - Location: SOUTH KITCHEN FRIDGE
Violation Issued: No

Type: Full
Date: *08/07/23*
Time: 12:00:02
Report: 7939231128
Oak Hill Assisted Living

Food and Beverage Establishment Inspection Report

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

DISCUSSION
PLEASE REVIEW THE ORDER CONCERNING THE WARE WASH MACHINE TEMPERATURE. TEST STICKERS LEFT WITH SARAH.

MIDNIGHT SHIFT PREPS AND COOKS THE MEALS FOR THE DAY SHIFT. PLEASE REVIEW THE EMAILED FACT SHEETS WITH ALL KITCHEN EMPLOYEES AND ADJUST COOKING PRACTICES ACCORDINGLY.
COOLING FACT SHEETS EMAILED TO KYLE.

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939231128 of 08/07/23.

Certified Food Protection Manager: SARAH GREEN

Certification Number: FM011638 Expires: 11/19/25

Signed: _____
KYLE HEDLUND
MANAGER

Signed: _____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us