Electronically Delivered

August 29, 2024

Licensee
Moorhead Manor
1710 13th Avenue North
Moorhead, MN 56560

RE: Project Number(s) SL30439015

Dear Licensee:

On July 30, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on May 2, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 2, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 2, 2024, found not corrected at the time of the July 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0480 - Minimum Requirements - 144g.41 Subd 1 (13) (i) (b)
0485 - Minimum Requirements - 144g.41 Subdivision 1. (13)(i)(a)and(c)
0930 - Contract Information - 144g.50 Subd. 2 (d-E; 1-4)
1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E) - $500.00
1910 - Disposition Of Medications - 144g.71 Subd. 22

The details of the violations noted at the time of this follow-up survey completed on July 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

Also, at the time of this follow-up survey completed on July 30, 2024, we identified the following violation(s):

0250 - Conditions - 144g.20 Subdivision 1
0510 - Infection Control Program - 144g.41 Subd. 3
1760 - Documentation Of Administration Of Medication-144g.71 Subd. 8
1950 - Administration Of Treatments And Therapy - 144g.72 Subd. 4

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

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

IMPOSITION OF FINES:

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

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

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

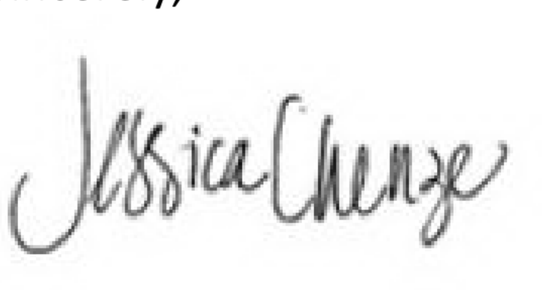
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30439	A. BUILDING: _____ B. WING _____	R 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30439015-1 On July 29, 2024, through, July 30, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 2, 2024. At the time of the survey, there were 16 residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued and new orders were identified.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the 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: No further action required.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living	{0 485}		

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{0 485}	Continued From page 2 contract. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial entrance conference on April 29, 2024, at 10:34 a.m., licensed assisted living director (LALD)-A stated the licensee provided residents three meals per day and was included in the residents assisted living contract. On page one of the [name of facility] Assisted Living Contract Agreement, section 7, Base Rent: indicated the licensee offers a number of services as part of your (resident) monthly base rent. The services included in the base rate are: three meals daily, two snacks ... Resident assisted living contracts lacked an option for residents to opt out of payments for any meals residents would not want. On July 29, 2024, at 3:01 p.m., LALD-A stated three meals per day had been included in the base pay of all assisted living contracts, adding all but one resident's insurance reimbursed for all three meals per day. LALD-A said a new contract had been prepared and signed by the private pay resident, the only resident who did not have insurance that would reimburse for meals. LALD-A stated there was a "misunderstanding"	{0 485}		

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{0 485}	Continued From page 3 and she was not aware an option to opt out of meal plans was required on all contracts. LALD-A confirmed only one contract had been updated as required. No further information was provided.	{0 485}		
0 510 SS=D	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 record review, the licensee failed to ensure infection control standards were followed by one of one licensed practical nurse (LPN)-G) by disinfecting shared equipment in between resident use (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 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	0 510		

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0 510	Continued From page 4 situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, anxiety, hypertension (HTN-high blood pressure), and neuropathy (disease effecting nerves). R2's service plan, dated April 1, 2024, indicated services included blood pressure (BP) monitoring four days a week. On July 30, 2024, at 7:07 a.m., the surveyor observed LPN-G administer R2's morning medication. LPN-G removed a wrist BP cuff from a basket of monitoring equipment and placed the BP cuff onto R2's right wrist. The surveyor did not observe LPN-G clean the BG cuff prior to application. LPN-G obtained a BP reading of 118/44. LPN-G removed the BP cuff from R2's wrist and placed the BP cuff into the basket of monitoring equipment. The surveyor did not observe LPN-G clean the wrist BG cuff after taking R2's BP and before she placed the cuff into the basket. On July 30,2024, at 7:30 a.m., LPN-G stated she should have cleaned the BP cuff, "right away" (after use), adding I should do all of them (motioning to a basket of equipment.) On July 30, 2024, at 9:24 a.m., registered nurse (RN)-F stated her expectation was shared equipment would be cleaned in-between each use. RN-F added she would clean equipment before and after use. RN-F confirmed the BP cuff was not cleaned as required. The licensee's Infection Control policy dated August 1, 2021, noted (name of facility) would	0 510		

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0 510	Continued From page 5 implement and maintain processes to ensure all reusable resident care equipment was routinely cleaned and when appropriate, disinfected, before and after reuse. Common shared resident care equipment may include: -stethoscopes -glucometers not limited to individual resident use -mechanical lifts -etc. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider;	{0 930}		

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{0 930}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R2). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnosis included diabetes, anxiety, hypertension (HTN-high blood pressure), and neuropathy (disease effecting nerves). R2's service plan, dated April 1, 2024, indicated services included assistance with medication administration four times daily, blood glucose monitoring three times daily, socialization, and laundry. On July 30, 2024, at 7:07 a.m., the surveyor observed licensed practical nurse (LPN)-G check R2's blood sugar level, take R2's blood pressure, and administer R2's morning medication. R2's [name of facility] Assisted Living Contract Agreement revised and updated August 2021, and authenticated February 1, 2023, lacked contact information for the Ombudsman for Mental Health and Developmental Disabilities.	{0 930}		

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{0 930}	Continued From page 7 On July 29, 2024, at 1:59 p.m., licensed assisted living director (LALD)-A stated there was a misunderstanding, adding she updated one contract, R10's. LALD-A added she did not "go back through" and update any of the other resident's contracts. LALD-A confirmed the assisted living contracts provided to all, but one resident (R10) lacked contact information for the Ombudsman for Mental Health and Developmental Disabilities. LALD-A further stated Ombudsman for Mental Health and Developmental Disabilities was on the Minnesota Bill of Rights for Assisted Livings. No further information was provided.	{0 930}		
{01620} SS=F	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	{01620}		

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{01620}	Continued From page 8 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 a registered nurse (RN) conducted 14-day reassessments with the uniform assessment tool that included all required content for one of one resident (R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial entrance conference on April 29, 2024, at 10:28 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R10's diagnoses include bi-polar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings,) manic depression, alcoholism, and Parkinson's disease (long-term degenerative disorder of the central nervous system that affects the motor system.) On July 30, 2024, at 7:18 a.m., the surveyor observed licensed practical nurse (LPN)-G	{01620}		

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{01620}	Continued From page 9 administer R10's morning medication. R10's Client (resident) Monitoring & Reassessment 14 Day Reassessment dated May 16, 2024, included: -room clean, yes -client clean & dressed, yes -bathing, yes -medication administration, staff assist, yes -grooming, yes -oral cares, yes -foot cares, yes -incontinence, yes -new mental health issues present, no -other cares to add, blank -client satisfied with cares? yes -client needs met? yes -needs assessed that client refuses, blank -client informed of risks with refusing? yes -service plan changes, no -service plan updated, not needed. R10's Client Monitoring & Reassessment 14 Day Reassessment form lacked the following content of the uniform assessment tool: -the resident's personal lifestyle preferences, including: -sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; and -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. -physical health status including: -a review of relevant health history and current health conditions including medical and nursing	{01620}		

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{01620}	Continued From page 10 diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -infectious conditions; -a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: -the reason taken; -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -the dosage; -the frequency of use; -the route administered or taken; -any difficulties the resident faces in taking the medication; -whether the resident self administers the medication; -the resident's preferences in how to take medication; -interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and -provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -nutritional and hydration status and preferences;	{01620}		

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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
{01620}	Continued From page 11 -list of treatments, including type, frequency, and level of assistance needed; -risk indicators, including: -risk for falls including history of falls; -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including: -the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -the scope of decision-making authority of a substitute decision maker. On July 29, 2024, at 1:17 p.m., registered nurse (RN)-F stated there was some confusion regarding the 14-day assessment, adding they did not "even think" about the 14-day assessment tool. RN-F stated the tool used by the licensee for the 14-day assessment was not the universal tool used for initial and 90-day assessments. On July 30, 2024, at 8:28 a.m., LALD-A stated the 14-day assessment was not "in our minds." LALD-A asked where did it say that a universal tool needed to be used for the 14-day assessment? LALD-A later confirmed the	{01620}		

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	30439	A. BUILDING: _____ B. WING _____	R 07/30/2024

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{01620}	Continued From page 12 licensee was not aware that the 14-day assessment required a universal assessment. The licensee's 6.03 Uniform Assessment Tool policy dated August 1, 2021, indicated the licensee will use a uniform assessment tool that addresses all of the required elements, including each area noted above. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2020, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. The licensee's Assessment Schedules policy dated August 1, 2021, indicated resident reassessment and monitoring would be completed no more than 14 calendar days after the initiation of services and referred to MN 144G.70 Subd. 2 (b) and MN 4659.0140 Subd. 2. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and	{01620}		

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{01620}	Continued From page 13 (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided.	{01620}		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the steps of the medication administration process was followed for one of one employee, (licensed practical nurse (LPN)-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) 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).	01760		

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01760	Continued From page 14 The findings include: On July 30, 2024, at 6:23 a.m., LPN-G stated "they" (staff) have a routine, medications are set out, medication administration record (MAR) sheet is "up" (out) and added she (LPN)-G normally signs the medications off as she puts them into the medication cup. LPN-G added if a resident does not take a medication she goes back and circles the medication was not given on the MAR and writes about it. On July 30, 2024, at 6:41 a.m., the surveyor observed LPN-G prepare R11's medication. LPN-G compared each of R11's medication in medication cassettes (medication system in-place) to R11's MAR, and signed the medication as given when the medication was placed into the medication cup. On July 30, 2024, at 6:46 a.m., LPN-G administered R11's morning medication. On July 30, 2024, at 6:47 a.m., LPN-G stated they (R11's medications) were done, adjusted the medication cassettes and returned them to a rack/box used and stated I'll go down and do R9. LPN-G prepared R9's morning medications. LPN-G signed each medication as given once it was placed into the medication cup. LPN-G went to R9's room to administer R9's morning medication. R9's medication spilled onto R9's bed. LPN-G gathered the medications and went back to the medication room and discarded the medication that had been prepared. LPN-G prepared R9's morning medication, returned to R9's room and administered R9's morning medication.	01760		

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01760	Continued From page 15 On July 30, 2024, at 7:00 a.m., the surveyor observed R2 come to the nurse's office and LPN-G removed two red cassettes from a locked medication drawer, gather blood sugar testing supplies and a blood pressure cuff. LPN-G asked R2 to rate her pain. LPN-G looked at R2's MAR and put a medication from each of the red cassettes into a medication cup, marking the medication off in the MAR as given when LPN-G put the medication into the medication cup. On July 30, 2024, at 7:07 a.m., LPN-G prepared a Lantus (long-acting insulin) pen for R2 using correct technique and handed the pen to R2. R2 self-administered the Lantus insulin. The surveyor did not observe LPN-G document R2's insulin as administered. On July 30, 2024, at 8:36 a.m., the surveyor reviewed R2's MAR with LPN-G. LPN-G stated she did not document R2's insulin as administered, adding she "stopped right here" (pointing to a line on R2's MAR./documenting in R2's MAR.) LPN-G said, at the end of the shift "I always go back through and make sure I documented all" (medications). On July 30, 2024, at 10:14 a.m., registered nurse (RN)-F stated medication documentation should be done in "real time." RN-F said she had gone back and forth on the documentation adding "either way was ok." (To document as medication is put into the medication cup or after medication was given.) The licensee's Medication Management policy was reviewed with RN-F and RN-F confirmed medications should be documented after medication administration. The licensee's Medication Management-Administration & Setup policy dated	01760		

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01760	Continued From page 16 August 1, 2021, noted: -documentation of a 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		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's	{01910}		

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{01910}	Continued From page 17 record the disposition of the medications as required for one of one resident (R7) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the initial entrance conference on April 29, 2024, at 10:32 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. The licensee's undated Discharged or Deceased Resident Roster indicated R7 was admitted on November 8, 2023, and was discharged on July 1, 2024. R7's diagnoses included hepatic encephalopathy (altered level of consciousness due to liver failure), high blood pressure (HTN,) and elevated blood sugars. R7's Service Plan part 2 (two) dated November 28, 2023, indicated R7 received medication administration services up to five times per day. R7's Medication Administration Record (MAR) dated May 1, 2024, through May 31, 2024, indicated R7 received the following medications: -Tresiba FlexTouch (long-acting insulin) 100 units/	{01910}		

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{01910}	Continued From page 18 milliliter (ml), prime pen with two units before each use, inject 64 units under the skin one time a day -glucose (sugar) four grams chew, take one tablet by mouth as offer as necessary for hypoglycemia less than 70 (low blood sugar) -Fiasp FlexTouch (rapid acting insulin) 100 units/ml pen with two units before each use. Inject 37 units under the skin three times daily with meals. R7's prescriber orders dated April 24, 2024, and April 29, 2024, included the above noted medications. R7's Disposition of Medications Returned to (name) Pharmacy dated July 1, 2024, included: -Tresiba pens, four pens -glucose tabs, two bottles -Fiasp, five pens. R7's record included Progress Note, dated July 1, 2024, noted: -Discharged from (name of facility) discharged per brother's (name) requested until determined, per discharged hospitalization plan. R7 s record lacked documentation for the disposition of the above medications to include the medication strength. On July 29, 2024, at 1:19 p.m., registered nurse (RN)-F stated she should have included the medication strength on R7's discharge record. The licensee's 7.23 Medication Disposal policy dated June 1, 2024, noted unused prescription drugs medications, upon disposition, the facility must document in the resident's record the disposition of the medication including the	{01910}		

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{01910}	Continued From page 19 medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, ad names of staff and other individuals involved in the disposition. No further information was provided.	{01910}		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to 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 one of one resident (R2) receiving blood pressure monitoring.	01950		

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01950	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, anxiety, hypertension (HTN-high blood pressure), and neuropathy (disease effecting nerves). R2's service plan, dated April 1, 2024, indicated services included blood pressure (BP) monitoring four days a week. On July 30, 2024, at 7:07 a.m., the surveyor observed licensed practical nurse (LPN)-G remove a wrist BP cuff from a basket of monitoring equipment and placed the BP cuff onto R2's right wrist. LPN-G obtained a BP reading of 118/44. R2's prescriber order dated March 7, 2024, included: -let me know if systolic BP consistently less than 100 -check BP three-four times a week -follow up in one year, or sooner if needed. R2's Individualized Treatment or Therapy Management Plan dated March 7, 2024, included: -check BP three to four times week -monitor systolic if consistently less than 100 contact cardiologist.	01950		

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01950	Continued From page 21 R2's BP & Pulse Record dated July 2024, with R2's medication administration record (MAR) noted: -MD (medical doctor) order, Monday, Tuesday, Thursday, Friday -date, sitting blood pressure, pulse, notes -reading ranged from 128/88, to 79/40. R2's record did not include specific instructions for R2's BP monitoring. On July 30, 2024, at 10:12 a.m., registered nurse (RN)-F stated R2's record did not include specific information as required. RN-F stated they (licensee) had "hit" records really hard (reviewed and updated) but missed R2's BP monitoring. The licensee's Treatment & Therapy Management Plan dated August 1, 2021, noted (name) would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services -any resident-specific requirements related to documentation of treatment and therapy received -monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

Electronically Delivered

May 23, 2024

Licensee
Moorhead Manor
1710 13th Avenue North
Moorhead, MN 56560

RE: Project Number(s) SL30439015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. 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. 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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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 MDH within 15 calendar days of the correction order receipt date.

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

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

correction order receipt date. 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. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	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: SL30439015 On April 29, 2024, through May 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 residents; all of whom were receiving services under the provider's Assisted Living license. An immediate correction order was identified on May 1, 2024, issued for SL30439015, tag identification 0470. On May 2, 2024, at 1:10 p.m., the immediacy of correction order 0470 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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	30439	A. BUILDING: _____ B. WING _____	05/02/2024

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

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0 470	Continued From page 2 residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). **REVISED for identifier change from O/KA-D to ULP-D to reflect intended job duties** This resulted in an immediate correction order identified on May 1, 2024. The findings include: The licensee held a license as an assisted living facility (ALF) with a census of 17 residents, all of whom received services under the ALF. During the entrance conference on April 29, 2024, at 10:28 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Clinical Nurse Supervisor (CNS) Staffing Plan dated February 1, 2023, included the following: -Monday through Friday nurse PRN (as needed) changing and flexible schedule weekly as noted on daily staffing post; daily available if not on site by phone; -Monday through Friday LPN (licensed practical nurse) 9:00 a.m. to 4:00 p.m. can vary based on resident need or staffing need; -Monday through Sunday UPersonnel [sic]	0 470		

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0 470	Continued From page 3 (unlicensed personnel (ULP)) 6:30 a.m. to 2:30 p.m., and 3:30 p.m. to 10:30 p.m.; -Monday through Sunday Overnight staff 10:30 p.m. to 6:30 a.m.; -Monday through Friday Home mgt [sic] (management) staff UP (ULP) and or universal worker [sic] 8:30 a.m. to 3:30 p.m.; and -Monday through Friday Assisted Living Director (LALD) 8:30 a.m. to 4:00 p.m. but also available PRN on site as needed or scheduling requires to fill. On April 29, 2024, at 2:42 p.m., LALD-A and CNS-B stated the licensee's staffing plan does not change much and the staffing plan was only reviewed one time per year. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated April 20, 2023, indicated the number of unlicensed direct care staff typically scheduled per shift were: -Day shift: three to four unlicensed direct care staff; -Evening shift: one to two unlicensed direct care staff; and -Night shift: one unlicensed direct care staff. R2's diagnosis included diabetes, anxiety, hypertension (HTN-high blood pressure), and neuropathy (disease effecting nerves). R2's record indicated R2 received a copy of the licensee's UDALSA on February 1, 2023. R2's Service Plan part 2 (two) dated April 1, 2024, indicated R2 received medication administration four times per day including PRN's per doctor's orders, and blood sugar checks three times per day provided by the AL (assisted living) care	0 470		

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0 470	Continued From page 4 team. R2's prescriber order dated April 18, 2024, was an order for Acetaminophen 500 milligrams (mg) take 2 tablets by mouth three times daily as needed for pain. R2's prescriber orders dated March 25, 2024, indicated to check blood glucose twice daily and as needed. R2's Client (resident) Individualized Medication MGT. (management) Plan dated February 1, 2024, indicated licensee home care staff provided medication administration. On May 1, 2024, from 11:04 a.m., through 11:09 a.m., the surveyor interviewed R2. R2 stated R2 only has had to call for assistance at night when R2 first moved to the facility in February 2023. R2 stated if R2 would need a PRN medication at night it is administered by staff at the facility. R2 further stated RNs on call have come onsite for any needs regarding R2's blood sugar. ULP-D was hired to provide onsite overnight awake staff for residents and assistance with help in the kitchen at the facility. ULP-D's Housekeeper/Overnight Staffing job description dated January 16, 2024, included the following overnight awake services to provide: -Monitor hallways throughout the overnight in case resident may need assistance; -Upon resident request prove a "room" check, otherwise residents are not disturbed; -Respond to any call button system for resident; -Contact 911 services as may be needed; -Updated Assisted Living Director (LALD), Supervising or on call RN (registered nurse) as	0 470		

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0 470	Continued From page 5 required. From March 1, 2024, through April 28, 2024, the overnight schedule provided by the licensee indicated ULP-D had worked alone 10:30 p.m. until 6:30 a.m., 15 out of 59 overnight shifts. On April 30, 2024, at 6:02 a.m., the surveyor entered the facility and ULP-D was the only staff present at the facility. ULP-D stated when ULP-D worked nights the job details included laundry, cleaning, disinfecting, preparing for breakfast, and assisting residents for any needs. ULP-D stated ULP-D had just been trained to pass medications for PRN medications residents may need during the night. ULP-D's employee record lacked training and/or competency testing for the following areas: -consumer advocacy services; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and sue of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of commonly used health technology equipment and assistive devices; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;	0 470		

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0 470	Continued From page 6 -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; range of motion and positioning; -administering medications on all routes; and -blood glucose checks/monitoring. On April 29, 2024, at 2:59 p.m., CNS-B stated some overnight staff are not trained to do medications or check blood sugars. The procedure for the overnight staff would be to contact the registered nurse (RN) on call and the RN would be expected to come in. CNS-B stated both RNs on call lived approximately five minutes away from the facility. CNS-B further stated the licensee was working on training all overnight staff to be trained to aid all residents including medication administration and any delegated treatments or tasks. On April 30, 2024, at 9:45 a.m., LALD-A stated ULP-D was the kitchen aide only up until last week due to complications with ULP-D's background study. LALD-A further stated overnight staff is in the process of being trained to administer medications, however, the process for overnight workers would be to call the RN on call and have the RN come in to give a PRN medication to a resident if needed. LALD-A stated that PRN medications are never given at night to residents. On April 30, 2024, at 1:52 p.m., LALD-A stated ULP-D is not a ULP and does work the overnight shift alone. LALD-A stated the licensee's UDALSA was incorrect and should not indicate that one ULP is at the facility during the overnight shift. LALD-A again stated the process of any	0 470		

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0 470	Continued From page 7 residents' cares or needs at night would be to contact the RN on call and the RN would be expected to come in and provide the service needed. LALD-A further stated with the current census of the residents the licensee doesn't do assistance with toileting, bed transfer, gait belt, or typically provide medication administration or delegated tasks during the overnight hours of 10:30 p.m. until 6:30 a.m. On April 30, 2024, at 3:14 p.m., LALD-A stated ULP-D's previous work experience included a home health aide (HHA) certification for a different state, however, for this licensee ULP-D job was classified as an overnight worker. On May 1, 2024, at 10:00 a.m. RN-F stated RN-F had not completed any training or competency testing regarding medication administration or delegated treatment or tasks for ULP-D. RN-F further stated the expectation if a resident needed a PRN medication or any assistance would be for ULP-D to contact the RN on call and the RN on call would need to come in. RN-F stated RN-F only recalled having to come in one time over the past year RN-F has been on call related to a resident fall. On May 1, 2024, at 10:13 a.m., LALD-A brought in competency testing for ULP-D that was forgotten to be brought into the surveyor yesterday (April 30, 2024). The competency testings were dated February 12, 2024, and indicated ULP-D passed liquid medication administration, meter dose inhaler, narcotic administration, and oral medications. All four competencies were signed by CNS-B, however, lacked ULP-D's signatures. The surveyor inquired why competency testing was done in those four areas prior to ULP-D's training listed on Educare	0 470		

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0 470	Continued From page 8 (online training platform). ULP-D's Educare transcript indicated ULP-D's medication overview training was completed on February 25, 2024 (13 days after passed competency testing noted above). LALD-A stated the RNs do a competency testing to see where staff is at in conjunction with the training and the RNs would not fully pass medication administration competency until the ULP is ready. A ULP would never work the floor (shift) alone until all training and competency is finalized. On May 1, 2024, at 10:35 a.m., and 12:01 p.m., respectively, the surveyor left voicemails for CNS-B. On May 1, 2024, at 1:25 p.m., CNS-B stated CNS-B had completed and signed the four competencies noted above on February 12, 2024, with ULP-D. CNS-B further stated CNS-B was informed after the competency testing, ULP-D had not completed all Educare training regarding medications. CNS-B informed the licensee to disregard the medication competency testing from February 12, 2024, and would need to reschedule competency testing with ULP-D, once ULP-D had completed all required training. CNS-B stated the competencies for ULP-D dated February 12, 2024, could be used as a tool to assess to see ULP-D's knowledge, however, all competency testing would need to be completed once ULP-D's Educare training was completed. The licensee's Staffing Policy and Procedure policy dated August 1, 2021, indicated the CNS must ensure that staffing levels are adequate to address the following: -each resident's needs, as identified in the resident's service plan and assisted living contract;	0 470		

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0 470	Continued From page 9 -each resident's acuity level, as determined by the most recent assessment or individualized review; -the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; -whether the facility has a secured dementia unit; and -staff experience, training, and competency. The Staffing Policy and Procedure policy further indicated the following: -during the hours of 10:00 p.m. to 6:00 a.m., direct-care staff shall respond to a resident's request for assistance with health or safety needs within a reasonable amount of time; -The CNS would conduct an evaluation at least twice per year, the appropriateness of staffing levels in the facility; -Overnight staff consist of one direct care staff on sight to supervise and respond as needed in a timely manner; and -staff experience, training and competency are completed as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 1., effective October 2022, the definition of direct-care staff means staff who provide services for residents that include assistance with activities of daily living, medication administration, resident-focused activities, supervision, and support. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3., effective October 2022, the CNS must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a	0 470		

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0 470	Continued From page 10 week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; -the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; -whether the facility has a secured dementia unit; and -staff experience, training, and competency. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 6., effective October 2022, during the hours of 10:00 p.m. to 6:00 a.m., direct-care staff shall respond to a resident's request for assistance with health or safety needs within a reasonable amount of time as provided in Minnesota Statutes, section 144G.41, Subp.1, clause (12), item (ii). No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor review on May 2, 2024, at 1:10 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 11 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 485		

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0 485	Continued From page 12 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 29, 2024, at 10:34 a.m., licensed assisted living director (LALD)-A stated the licensee provided residents three meals per day and was included in the residents assisted living contract. On page one of the [name of facility] Assisted	0 485		

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0 485	Continued From page 13 Living Contract Agreement, section 7 (seven), Base Rent: indicated the licensee offers a number of services as part of your (resident) monthly base rent. The services included in the base rate are: three meals daily, two snacks ... Resident assisted living contracts lacked an option for residents to opt out of payments for any meals residents would not want. On April 30, 2024, at 9:14 a.m., LALD-A stated three meals per day were included in the base pay of all assisted living contracts since most of the resident's insurance reimbursed for all three meals per day. LALD-A further stated there was one resident that was private pay and was not given an option to opt out of three meals per day. LALD-A stated the licensee was not aware that an option to opt out of meal plans was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 14 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and post the EPP prominently. In addition, the licensee failed to review the missing resident plan at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on April 29, 2024, from 12:15 p.m. until 12:32 p.m., with licensed assisted living director (LALD)-A, the surveyor did not	0 680		

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0 680	Continued From page 15 observe the EPP or EPP signage posted. Immediately following the facility tour, LALD-A stated the licensee did not post signage for residents, staff, or visitors on where to locate the EPP. The licensee's EPP lacked the following content and/or policies and procedures to address: - evacuation plan which included staff responsibilities during an evacuation; - a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; and - missing resident plan that was reviewed quarterly. On May 2, 2024, at 12:05 p.m., clinical nurse supervisor (CNS)-B stated the licensee reviewed the missing resident policy approximately every six months and the licensee was not aware the policy needed be reviewed at least quarterly. On May 2, 2024, at 12:15 p.m., LALD-A stated the licensee's EPP was a work in progress and had not completed all required content of the EPP, however, had been working with the county where the licensee was located. The licensee's 9.01 EPP-Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's EPP would include all required elements of appendix [sic] Z. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated the licensee would review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented.	0 680		

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0 680	Continued From page 16 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the LALD and CNS must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what	0 930		

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0 930	Continued From page 17 circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R2, R7). This had the potential to affect all 17 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2's service plan, dated April 1, 2024, indicated services included assistance with medication administration four times daily, blood glucose monitoring three times daily, socialization, and laundry. On April 30, 2024, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled morning medication.	0 930		

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0 930	Continued From page 18 R7 R7's service plan, dated November 28, 2023, indicated services included medication administration five times daily, blood glucose monitoring four times daily, socialization, bath reminders, and laundry. On April 30, 2024, at 8:28 a.m., the surveyor observed ULP-C complete a blood glucose reading and administer R7's scheduled morning insulin. R2 and R7's [name of facility] Assisted Living Contract Agreement dated February 1, 2023, and November 8, 2023, respectively, lacked contact information for the Ombudsman for Mental Health and Developmental Disabilities. On April 30, 2024, at 9:13 a.m., licensed assisted living director (LALD)-A stated the assisted living contract provided to all residents lacked contact information for the Ombudsman for Mental Health and Developmental Disabilities. LALD-A further stated Ombudsman for Mental Health and Developmental Disabilities contact information should have been listed since the licensee served many residents with mental health diagnoses. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 19 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and	01060		

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01060	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative: and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated Discharged or Deceased Resident Roster indicated R1 was admitted on January 25, 2020, and was discharged on February 15, 2024. R1's Service Plan part 2 (two) dated August 1, 2022, indicated R1 received medication administration, assistance with bathing, dressing, laundry, and housekeeping. R1's Progress Notes included the following: -February 8, 2024, at 9:45 a.m., R1 was sent by ambulance to the emergency room for worsening cough, nausea and vomiting all night, color pale [sic], and complained of sore throat and heart burn.	01060		

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01060	Continued From page 21 -February 8, 2024, at 3:00 p.m., licensee was notified R1 was being admitted to the hospital. -February 15, 2024, the licensee received notice of R1's death at the hospital. R1's Client Transfer Information dated February 15, 2024, indicated R1 was transferred (discharged) [sic] on February 15, 2024, due to death. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On May 2, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-F stated a written emergency relocation was not completed for R1. CNS-B and RN-F further stated no residents or the OOLTC would have received written notification for emergency relocation as the licensee was not aware of the requirement and had thought emergency	01060		

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01060	Continued From page 22 relocation only applied to nursing home residents. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated the facility would provide a written notice to the resident, legal representative, and designated representative that contained, at a minimum, the following: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. In addition, the policy indicated the OOLTC would receive the above noted information from the licensee if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 23 (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 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	01470		

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01470	Continued From page 24 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (unlicensed personnel (ULP)-D). 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 April 29, 2024, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee records. ULP-D was hired on January 18, 2024, to provide onsite overnight awake staff for residents and assistance with help in the kitchen at the facility. On April 30, 2024, at 6:02 a.m., the surveyor entered the facility and ULP-D was the only staff	01470		

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01470	Continued From page 25 present at the facility. ULP-D stated when ULP-D worked nights the job details included laundry, cleaning, disinfecting, preparing for breakfast, and assisting residents for any needs. ULP-D's employee record lacked training regarding 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 advocacy services. On April 30, 2024, at 9:45 a.m., LALD-A stated ULP-D was the kitchen aide only up until last week due to complications with ULP-D's background study. On May 2, 2024, at 12: 14 p.m., LALD-A stated ULP-D had not completed all required assisted living orientation and the licensee was aware of required assisted living orientation content. The licensee's 5.01 Orientation of Staff and Supervisors and Content [sic] policy dated August 1, 2021, indicated all [facility name] employees must complete orientation to assisted living facility requirements before providing assisted living services to residents, which included 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. No further information was provided.	01470		

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01470	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 April 29, 2024, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of the employee records.	01550		

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01550	Continued From page 27 ULP-D was hired on January 18, 2024, to provide onsite overnight awake staff for residents and assistance with help in the kitchen at the facility. On April 30, 2024, at 6:02 a.m., the surveyor entered the facility and ULP-D was the only staff present at the facility. ULP-D stated when ULP-D worked nights the job details included laundry, cleaning, disinfecting, preparing for breakfast, and assisting residents for any needs. ULP-D's employee record lacked a total of four hours of the required dementia training was completed within 160 hours of the employee's start date. On April 30, 2024, at 9:45 a.m., LALD-A stated ULP-D was the kitchen aide only up until last week due to complications with ULP-D's background study. On May 2, 2024, at 12:12 p.m., LALD-A stated ULP-D had worked 192 hours for the licensee. LALD-A further stated the licensee was aware dementia training was required, however, training for ULP-D had been put on hold due to complications with ULP-D's background study. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated non-direct care staff will complete four hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		

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01620	Continued From page 28	01620		
01620 SS=F	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 a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for two of two residents (R2, R7). 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	01620		

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01620	Continued From page 29 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 29, 2024, at 10:28 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnosis included diabetes, anxiety, hypertension (HTN-high blood pressure), and neuropathy (disease effecting nerves). R2's Client (resident) Monitoring 90 Day Reassessment Forms were completed November 20, 2023, and February 18, 2024, respectively. On April 30, 2024, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled morning medications. R7 R7's diagnoses included hepatic encephalopathy (altered level of consciousness due to liver failure), HTN, and elevated blood sugars. R7's Client (resident) Monitoring 90 Day Reassessment Form was completed February 26, 2024. On April 30, 2024, at 8:28 a.m., the surveyor observed ULP-C administered R7's scheduled morning insulin. R2 and R7's Client (resident) Monitoring 90 Day Reassessment Forms lacked the following	01620		

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01620	Continued From page 30 content of the uniform assessment tool: -the resident's personal lifestyle preferences, including: -sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -spiritual and cultural preferences; and -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order. - physical health status including: -a review of relevant health history and current health conditions including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -infectious conditions; - a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: -the reason taken; -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -the dosage; -the frequency of use; -the route administered or taken; -any difficulties the resident faces in taking the medication; -whether the resident self administers the medication; -the resident's preferences in how to take medication; -interventions needed in management of medications to prevent diversion of medication by	01620		

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01620	Continued From page 31 the resident or others who may have access to the medications; and -provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; - a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: -risk for falls including history of falls; -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; -who has decision-making authority for the resident, including:	01620		

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01620	Continued From page 32 - the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -the scope of decision-making authority of a substitute decision maker. On May 2, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-B and RN-F stated the licensee only used the uniform assessment tool for the initial resident admission assessment and for any resident reassessment, the licensee used a condensed assessment that did not contain all elements of the uniform assessment tool. CNS-B further stated the licensee was not aware of the requirement under the assisted living rules. The licensee's 6.03 Uniform Assessment Tool policy dated August 1, 2021, indicated the licensee will use a uniform assessment tool that addresses all of the required elements, including each area noted above. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 1, 2020, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to	01620		

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01620	Continued From page 33 N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=D	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 legible information including the opened-on date for time sensitive medication for one of two residents (R2). In addition, the licensee failed to monitor for expired stock medications in one of one medication storage cabinet. 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	01890		

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01890	Continued From page 34 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 April 29, 2024, at 10:32 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. TIME SENSITIVE MEDICATION - R2's opened Lantus Solostar 100 units/milliliter (mL) (used to help lower blood sugar) pen lacked the date the pen was opened and when the pen would expire. On April 29, 2024, at 2:08 p.m., unlicensed personnel (ULP)-C stated the R2's Lantus Solostar pen should have been dated when it was opened. On April 29, 2024, at 2:26 p.m., clinical nurse supervisor (CNS)-B stated staff is expected to document on the insulin pen the open date of each new insulin pen and when the insulin pen will expire. The manufacturer's instructions for Lantus Solostar dated May 2019, noted do not use more than 28 days after first opening. The licensee's 7.13 Medications-Prescription Drugs and Prohibition policy dated August 1, 2021, indicated all prescription drugs, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the	01890		

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01890	Continued From page 35 pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. EXPIRED MEDICATION On April 29, 2024, from 2:00 p.m. until 2:05 p.m., the surveyor reviewed the medication storage cabinet with CNS-B and noted the following expired medications labeled "stock" written in permanent black marker on each bottle: -opened bottle approximately ¼ full of acetaminophen 500 milligrams (mg) (used to treat pain or fever) bottle expired February 2024; and -opened bottle approximately ½ full of Mylanta (used to treat upset stomach or heartburn) expired March 2024. Immediately following the observation, CNS-B stated the two bottles labeled "stock" were employee medications and not managed by the licensee. The surveyor inquired why the bottles would be labeled stock if the medications belonged to the licensee's employees and if the medications were employees why were the medications in the medication cabinet where resident medications were stored, however, CNS-B stated CNS-B did not know. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated expired medications managed by the licensee will be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be stored consistent with the manufacturer's recommendations.	01890		

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01890	Continued From page 36 The licensee's Storage of Medication policy dated August 2022, indicated home care staff do not maintain any checks on expiration of the produces or appropriate labels in any manner for any over the counter drugs managed by the client (resident). The policy did not indicate if assisted living staff monitor for expired medications for medications managed by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 29, 2024, at 10:32 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. The licensee's undated Discharged or Deceased Resident Roster indicated R1 was admitted on January 25, 2020, and was discharged on February 15, 2024. R1's diagnoses included chronic obstructive pulmonary disease (COPD), adjustment disorder with mixed anxiety and depressed mood, and anxiety. R1's Service Plan part 2 (two) dated August 1, 2022, indicated R1 received medication administration services four times per day. R1's Medication Administration Record (MAR)	01910		

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01910	Continued From page 38 dated February 2024, indicated R1 received the following medications: -fluoxetine HCL 60 milligrams (mg) (antidepressant) daily -womens [sic] probiotic plus cranberry (supplement) 1 capsule daily -vitamin D3 50 micrograms (mcg) (supplement) daily -calcium 500 with vitamin D3 600 (supplement) daily -vitamin B-12 500 mcg (supplement) daily -ferrous sulfate 325 mg (supplement) daily -vitamin A 10,000 units (supplement) daily -folic acid 1 mg (supplement) daily -senna 8.6 mg (for constipation) twice daily -pantoprazole 40 mg (for heartburn) daily -calcium antacid 500 mg (for heartburn) three times daily -refresh tears 0.5% (for dry eyes) one drop into each eye while awake -famotidine 40 mg (for heartburn) daily -quetiapine 25 mg (for major depressive disorder) daily -melatonin 5 mg (sleep aid) daily -atorvastatin 40 mg (for high cholesterol) daily -benzonatate 100 mg (for cough) three times daily as needed -acetaminophen 650 mg (for pain or fever) every six hours as needed -bisacodyl 10 mg (for constipation) daily as needed -Spiriva 185 mcg (for bronchospasms) daily -fluticasone nasal spray 50 mcg (to prevent asthma attacks) one spray in each nostril daily -ipratropium 0.06% spray (for asthma) two sprays in each nostril twice daily -arthritis relief 0.025% (for arthritis) applied topical as needed -gavilax 17 grams (for constipation) daily as needed	01910		

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01910	Continued From page 39 -albuterol HFA 90 mcg (for COPD) two puffs every 4 hours as needed -delsym 30 mg/5 mL (for cough)- 5 mL every 12 hours as needed R1's prescriber orders dated February 2, 2024, included the above noted medications. R1's Client Transfer Information dated February 15, 2024, indicated R1 was transferred (discharged) [sic] on February 15, 2024, due to death and medication was returned to pharmacy. R1's record lacked documentation for the disposition of the above medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 2, 2024, at 11:34 a.m., clinical nurse supervisor (CNS)-B stated R1's medications were returned the pharmacy and not documented in R1's chart. CNS-B further stated the licensee's normal process is to return any medications to the pharmacy and to document medications had been returned. CNS-B stated the licensee was unaware of the requirement for disposition of medications and was unsure if the pharmacy documented the medications being returned. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated current unused medications managed by the licensee will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility, or the medication has been discontinued by the prescriber. Upon	01910		

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01910	Continued From page 40 disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, ad names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-C). In addition, the licensee failed to ensure the steps of the planned time away procedure was followed for one of one employee (licensed practical nurse (LPN)-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	02320		

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02320	Continued From page 41 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 April 29, 2024, at 10:32 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents at the facility. MEDICATION ADMINISTRATION PROCESS On April 30, 2024, at 7:28 a.m., the surveyor observed ULP-C conduct a blood glucose reading on R2. ULP-C then dialed R2's Lantus Solostar insulin pen to 18 units and handed the insulin pen to R2 to self-administer. R2 administered 18 units of Lantus into R2's abdomen and handed the Lantus Solostar insulin pen back to ULP-C. The surveyor did not observe ULP-C prime R2's Lantus Solostar insulin pen with two (2) units and discard before dialing up R2's 18 units of Lantus. On April 30, 2024, at 7:38 a.m., ULP-C stated ULP-C was trained to prime insulin pens with two (2) units of insulin and discard prior to dialing up the amount of insulin prescribed to be administered. ULP-C further stated ULP-C was nervous with the surveyor observing. On May 1, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated ULPs had been trained to prime insulin pens with two (2) units and discard before administering the prescribed insulin amount. In addition, CNS-B stated the resident's medication administration record (MAR) indicated to prime the insulin with two (2) units of insulin and discard for a reminder prior to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30439	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

(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
02320	Continued From page 42 administration of the insulin pen. The manufacturer's instructions for Lantus Solostar dated May 2019, indicated to select a dose of 2 (two) units, press the injection button, and check to make sure insulin comes out of the needle tip prior to dialing up the amount of insulin prescribed. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated to compare the insulin with the MAR and check for any special instructions. The policy did not address discarding two (2) units of insulin prior to administration of the full insulin dose. PLANNED TIME AWAY PROCEDURE On April 29, 2024, at 2:00 p.m., the surveyor reviewed the medication storage cabinet with ULP-C. Inside a drawer with R4's name contained a plastic baggie with four (4) tablets labeled quetiapine 50 milligrams (mg) HS (night) PRN. ULP-C stated the plastic baggie was not labeled with a resident name and ULP-C was unable to verify if the four (4) pills belonged to R4. On April 29, 2024, at 2:16 p.m., CNS-B stated CNS-B was unable to verify who the pills belonged to since a resident name was not listed on the plastic baggie and CNS-B would need to destroy the four (4) pills. CNS-B stated LPN-G set up R4's medications for R4's planned time away and did not follow the planned time away procedure to include R4's name. On April 29, 2024, at 3:18 p.m., CNS-B stated to LPN-G the planned time away procedure must also include the resident's name on all plastic baggies. LPN-G stated the four (4) pills were returned by R4 after R4 returned from R4's	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30439	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

(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
02320	Continued From page 43 planned time away. The licensee's 7.10 Medication Management-Planned and Unplanned Time Away policy dated August 1, 2021, indicated a licensed nurse must set up the resident's medications in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and the times [sic] that the medications are scheduled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30439	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD MANOR	1710 13TH AVENUE NORTH MOORHEAD, MN 56560

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03090	Continued From page 44 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on April 29, 2024, from 12:15 p.m. until 12:32 p.m., with licensed assisted living director (LALD)-A, the surveyor did not observe signage to disclose electronic monitoring activity. On April 29, 2024, at 12:32 p.m., LALD-A stated the licensee did not have any signage posting regarding electronic monitoring since the licensee did not have any security cameras and did not record people or activities. The licensee's 2.15 Electronic Monitoring policy dated August 1, 2021, indicated once a resident does make this request (electronic monitoring) and implement [sic] it (electronic monitoring) for themselves (resident), signs will be installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *04/29/24*
Time: 15:24:11
Report: 7935241009

Food and Beverage Establishment Inspection Report

Location:
Moorhead Manor
1710 13th Avenue North
Moorhead, MN56560
Clay County, 14

Establishment Info:
ID #: 0038028
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182366286
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.

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

RE-DATE COOKED CHICKEN REMOVED FROM FREEZER, SO IT IS CLEAR WHEN IT HAS REACHED 7 DAYS THAT IT HAS BEEN REFRIGERATED.

Comply By: 04/29/24

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

UNCOVERED COFFEE IN FOOD PREP AREA. MOVE TO A DESIGNATED AREA OR PROVIDE COVER.

Comply By: 04/29/24

4-200 Equipment Design and Construction

4-201.11AMN

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

DOMESTIC STOVE, SMALL DOMESTIC REFRIGERATOR, AND REFRIGERATOR IN DRY STORAGE ROOM ARE NOT ANSI CERTIFIED. REMOVE OR REPLACE WITH APPROVED EQUIPMENT.

Comply By: 11/30/24

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

DRY STORAGE ROOM HAS A POPCORN TEXTURED FINISH ON THE CEILING. THIS TYPE OF CEILING IS NOT EASILY CLEANABLE.

Comply By: 04/29/25

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

BASE COVE MISSING IN DRY STORAGE ROOM.

Comply By: 04/29/24

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Domestic cooler - DSR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: True upright cooler
Violation Issued: No

Process/Item: Cooking
Temperature: 218 Degrees Fahrenheit - Location: Fries
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Chili
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: Sauteed mushrooms/onions/peppers
Violation Issued: No

Type: Full
Date: *04/29/24*
Time: 15:24:11
Report: 7935241009
Moorhead Manor

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	4

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241009 of 04/29/24.

Certified Food Protection Manager Susan Diane Christianson

Certification Number: 3202 Expires: 12/23/26

Signed: _____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us