DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 15, 2025

Licensee
Plainview Estates
2507 Fairview Avenue
Cloquet, MN 55720

RE: Project Number(s) SL30619016

Dear Licensee:

On April 15, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 20, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 20, 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 November 20, 2024, found not corrected at the time of the April 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20

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.

The details of the violations noted at the time of this follow-up survey completed on April 15, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	R 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30619016-1 On April 15, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 20, 2024. At the time of the survey, there were seven residents; seven receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	{0 680}		

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{0 680}	Continued From page 3 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 15, 2025, at 12:01 p.m., licensed assisted living director (LALD)-A stated the licensee had updated the EPP after the last survey to include all required content of the EPP. The licensee's EPP dated March 1, 2025, lacked the following content and/or policies and procedures to address: -a risk assessment of potential hazards such as emergencies, equipment/utility failures, interruptions in communications, weather, infectious diseases, and disasters;	{0 680}		

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{0 680}	Continued From page 4 - process for EPP cooperation with state and local EP officials/organizations; In addition, the licensee lacked a communication plan that included: - a complete list of names and contact information for staff, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs. On April 15, 2025, at 3:19 p.m., house manager (HM)-D stated HM-D had worked on updating the licensee's EPP, however, the EPP was a work in progress and had lacked the above noted content. The licensee's undated Emergency Procedures; Fire, Sever Weather and Natural Disasters policy indicated the licensee will have a written plan of action to facilitate our resident's care and services in response to a natural disaster or another type of emergency that may affect our ability to provide services. 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:	{0 680}		

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{0 680}	Continued From page 5 Interpretive Guidance," which is incorporated by reference. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 6 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	

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{01890}	Continued From page 7	{01890}		
{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 (R4). 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 15, 2025, at 12:10 p.m., clinical nurse supervisor (CNS)-C stated the licensee completed an audit of the medication cart after the last survey to ensure all time sensitive medications were labeled with an open date and expiration date. On April 15, 2025, at 3:47 p.m., the surveyor reviewed the locked medication cart with unlicensed personnel (ULP)-G and observed R4's	{01890}		

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{01890}	Continued From page 8 opened Symbicort 160-4.5 micrograms (mcg) inhaler, which lacked an open date and expiration date. ULP-G stated all ULPs trained and retrained to ensure time sensitive medications were labeled with an open date and expiration date, however, R4's Symbicort inhaler lacked an open date and expiration date label. On April 15, 2025, at 3:51 p.m., CNS-C stated R4's Symbicort inhaler was not labeled with an open date or expiration date. CNS-C further stated CNS-C retrained all ULPs to label time sensitive medications with an open date and expiration date, however, the pharmacy must have missed placing an open date and expiration date label on R4's Symbicort inhaler. The manufacturer's instructions for Symbicort dated July 2019, indicated to discard Symbicort when the labeled number of inhalations have been used or within three months after removal from the foil pouch, whichever comes first. The licensee's Storage of Medications policy dated February 28, 2024, indicated until the medication was set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's (resident's) name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided.	{01890}		

Electronically Delivered

March 13, 2025

Licensee
Plainview Estates
2507 Fairview Avenue
Cloquet, MN 55720

RE: Project Number(s) SL30619016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 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 260.

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

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

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

The correction order documentation should include the following:

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Plainview Estates. Please contact Jessie Chenze at 218-332-5175 on or before **Tuesday, March 18, 2025**, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30619016 On November 18, 2024, through November 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were eight residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on May 17, 2022 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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0 340	Continued From page 2 of the residents). The findings include: On November 18, 2024, at 8:02 a.m., the surveyor asked licensed assisted living director (LALD)-A, during the survey announcement phone call, to have the licensee's corrective action plan (CAP) available for review. LALD-A stated she did not have the CAP "with her." The surveyor was not provided the licensee's CAP during the surveyor process. On November 20, 2024, at 12:53 p.m., the survey concluded, and the following orders were reissued from the previous survey: 0340, 0510, 0680, 0810, 0910, 0920, 0930, 0950, 1650, 1790, and 2310. In addition to the orders reissued, the following orders were issued: 0470, 0480, 0495, 0640, 0650, 0780, 1420, 1440, 1560, 1620, 1640, 1750, 1760, 1770, 1820, 1830, 1880, 1890, 1930, 1940, 1950, 1969, 1970, and 2320. On November 20, 2024, at approximately 11:00 a.m., the surveyor explained to clinical nurse supervisor (CNS-C and house manager (HM)-D what a CAP was and they both stated they thought creating a CAP was a good idea On November 20, 2024, at 12:50 p.m., during the exit conference HM-D stated she already started to put a CAP together. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		

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0 470	Continued From page 3	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a staffing plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 4 violation that did not harm a 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 held an assisted living license. The facility was licensed for a capacity of eight and had a current census of eight residents. On November 18, 2024, at 10:31 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-C and herself (LALD-A) developed the staffing plan and the staffing plan was evaluated at least twice yearly. House manager (HM)-D stated the daily staff schedule was: - one unlicensed personnel (ULP) worked days shift from 7:00 a.m. to 7:00 p.m. - one ULP worked from 7:00 p.m. until 7:00 a.m. On November 18, 2024, at approximately 3:15 p.m., the survey reviewed the facility's policy binder. In the front of the binder was the (Name of facility) Staffing Plan, authenticated by CNS-C on March 11, 2022, which noted: 1. Qualified direct-care staff must be available 24 hours per day, seven days per week to meet resident's needs. Staffing is determined by RN (registered nurse) assessment of the following: -each resident's individual needs, needs are identified in service plan and assisted living contract and care plan -assessment of each resident's acuity level as determined by the most recent assessment or review of the client. Assessments are to be	0 470		

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0 470	Continued From page 5 completed by the RN with any changes in resident's condition -staff must be able to meet the residents' needs in a timely manner, this includes both scheduled, foreseeable needs, as well as unscheduled or emergent needs -staff will have appropriate experience training and competencies evaluated, additional training will be provided if warranted -if at any time staff feel that a residents(s) acuity has increased, the staff person(s) are to notify owner or RN of such and an evaluation or reassessment would be immediately completed. Staff are to notify owner and/or RN if at any time they feel that they are unable to safely care for client(s) [resident(s)] or have concerns about the care that is provided to resident(s). On November 20, 2024, at 12:35 p.m., CNS-C stated there were no metrics used to determine the facilities staffing needs. HM-D gave the surveyor a form (same as noted above/Staffing Plan) authenticated October 16, 2023, December 18, 2023, March 31, 2024, June 30, 2024, September 30, 2024, respectively on the bottom of the form by CNS-C. CNS-C stated "it made sense" to use a metric to determine the staffing needs for the facility. CNS-C said she reviewed the staffing plan every 90 days and confirmed a metric was not used. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs an according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services in sufficient numbers to adequately provide the	0 470		

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0 470	Continued From page 6 services agreed to in the assisted living contract and the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480		

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0 480	Continued From page 7 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 480		

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0 480	Continued From page 8 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated Novebmer 19, 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		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 495		

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0 495	Continued From page 9 On November 18, 2024, at 10:04 a.m., licensed assisted living director (LALD)-A met the surveyor at the entrance of the facility and stated clinical nurse supervisor (CNS)-C was working at day surgery and could not be at the facility today. On November 18, 2024, at 10:12 a.m., during the entrance conference LALD-A stated CNS-C was on site three to four days a week, and "comes in at all times." LALD-A added she (CNS-C) had been "with us since 2020." LALD-A explained CNS-C was currently working at day surgery at (name of hospital) but LALD-A could call CNS-C if needed for the entrance conference. LALD-A added the licensee did not have any additional nurses. LALD-A said CNS-C had a watch (smart watch), and CNS-C could get and send text messages. LALD-A said "we" (licensee) could get a hold of the nurse practitioner (NP) who made rounds at the facility also, if needed, for some medication. LALD-A said the NP did not work for the licensee. On November 19, 2024, at 11:41 a.m., CNS-C stated she worked a 0.6 to a 0.7 (six to seven shifts a pay period) at day surgery. CNS-C said she normally gets a text message on her watch (smart watch) while at day surgery, if and when staff need to contact her. CNS-C added sometimes she does get phone calls also while at work. CNS-C said it was possible she would not be available, "my (CNS-C) best guess" would be for two to three hours, while working. CNS-C said normally, when she worked at day surgery, she (CNS-C) was done by 2:00 p.m. or 2:30 p.m. and was available then. On November 19, 2024, at 11:55 a.m., LALD-A stated the licensee used to have another RN who	0 495		

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0 495	Continued From page 10 quit. LALD-A said, "we" (licensee) were just talking about hiring a backup RN, the "other day." LALD-A confirmed she was aware of the requirement to have an RN available 24/7. Page two of R3's Care Plan dated October 29, 2024, noted RN would be on-site three to four times weekly and available by cell phone and text 24/7. The Resident Handbook/Program Plan authenticated by house manager (HM)-D November 15, 2024, noted basic services included: on-call nursing staff 24-hours a day. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
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	0 510		

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0 510	Continued From page 11 review, the licensee failed to ensure infection control standards were followed for one of one employee, (unlicensed personnel (ULP)-B) during medication administration for 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 19, 2024, at 7:28 a.m., the surveyor observed ULP-B remove R7's Metamucil 4 in 1 fiber (bowel health) container from the locked medication cart. ULP-B removed measuring spoons out of a drawer in the kitchen. ULP-B put a measuring spoon into the Metamucil powder and placed the medication into a glass, and repeated the action. ULP-B returned the measuring spoon back into the drawer in the kitchen. The surveyor did not observe ULP-B wash the measuring spoon after use. On November 19, 2024, at 8:19 a.m., the surveyor asked ULP-B about the measuring spoon used for R7's Metamucil administration. ULP-B stated she filled the measuring spoon up twice as it was a half a teaspoon measuring spoon and R7's order was for one teaspoon of Metamucil. ULP-B did not respond to placing the spoon back into the drawer after use. On November 20, 2024, at 10:51 a.m., the surveyor and clinical nurse supervisor (CNS)-C	0 510		

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0 510	Continued From page 12 went to look in the kitchen drawer ULP-B got the measuring spoon from. CNS-C looked at the measuring spoon (s) and stated, you can't read what these even are (two spoons both noted "1/2" (half), (one was larger than the other.) CNS-C confirmed the measuring spoon needed to be sanitized after use. On November 20, 2024, at 11:30 a.m., CNS-C stated she could not wait to toss "these" spoons. CNS-C said she was going to get one spoon to use for R7's Metamucil. CNS-C stated she thought it was an infection control issue, adding not everyone was on Metamucil. CNS-C said, the measuring spoon could have been used for baking measurements. CNS-C said the measuring spoon should not have been put back into the kitchen drawer without being sanitized, placed in the dishwasher. The licensee's Disposal of Contaminated Material and Equipment policy dated January 1, 2020, noted after completing any task that results in contaminated material, such as a wound dressing change, contaminated material must be disposed properly. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 640	Continued From page 13	0 640		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number in common areas and by telephones for resident use in the facility. This had the potential to affect residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, at 10:45 a.m., during a tour of the facility with licensed assisted living	0 640		

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0 640	Continued From page 14 director (LALD)-A and house manager (HM)-D, the surveyor did not observe 911 posted as required. On November 18, 2024, at 12:53 p.m., HM-D stated the facility did have a land line (phone) that could be used by residents. HM-D pointed to a phone in the kitchen area. The surveyor did not observe 911 on or near the telephone. HM-D stated there used to be a 911 sign "here" while pointing to an area in the kitchen near the phone. HM-D confirmed there was not currently a 911 sign placed on or near the telephone. HM-D said the 911 emergency sign was posted behind the door, which was open. HM-D stated 911 was not visible while the door was open. HM-D said the door was open "for the sun," adding the door was not open all the time. HM-D closed the door which was opened to show the surveyor the 911 sign. HM-D confirmed 911 emergency number was not posted as required. On November 18, 2024, at 1:03 p.m., the survey observed LALD-A inform HM-D that the 911 sign needed to be moved as the call 911 was not visible when the interior door was open. The licensee's Emergency Action Plan policy dated June 16, 2022, noted dialing 911 is the most common method for reporting emergencies. Proper emergency numbers should be posted on or near each phone. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 650	Continued From page 15	0 650		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of two employees, (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-F). 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	0 650		

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0 650	Continued From page 16 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-C CNS-C was hired on August 24, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On November 20, 2024, at 11:00 a.m., the surveyor observed CNS-C ask R2 if CNS-C could provide nail care. CNS-C's employee record included a performance review dated December 20, 2021. CNS-C's employee record did not include an annual performance review. CNS-C's employee record did not include an annual review of the licensee's policies and procedures. On November 18, 2024, at 12:32 p.m., house manager (HM)-D stated the licensee had staff sign a Policy Acknowledgement and Receipt form for annual review of policies and procedures. On November 18, 2024, at 12:34 p.m., the Policy Acknowledgement and Receipt form was reviewed with HM-D. The licensee's Policy Acknowledgement and Receipt form noted, "I understand this/these policies can be reviewed in the Policy and Procedure Manual and I may request a copy at any time." The form did not include CNS-C's name, signature and date.	0 650		

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0 650	Continued From page 17 HM-D stated she knew CNS-C reviewed the policies. HM-D said CNS-D did not sign the form as required. ULP-F ULP-F was hired on September 1, 2020, to provide direct care services to the licensee's residents. R2's medication administration record (MAR) dated November 15, 2024, through November 17, 2024, indicated ULP-F administered R2's 8:00 p.m., medication. ULP-F's employee record did not include an annual performance review. On November 19, 2024, at 8:30 a.m., licensed assisted living director (LALD)-A stated she does not do performance review for any of the staff. I (LALD-A) see them (employees), and I thank them (employees) every day, "we, (facility) is small." The licensee's Performance Review policy updated February 28, 2024, noted, our home care agency would conduct a performance review on new staff within the first 30 days/ months of beginning work and hereafter annually on the employee's anniversary date. The supervisor would complete the performance review form and ask the employee to sign and date it. The supervisor would retain a signed copy and a copy would be given to the employee. The completed performance review form would be given to the owner/director and RN (registered nurse) for any necessary follow up and then would be filed in the employee's personnel file. The licensee's Annual In-Service Training policy	0 650		

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0 650	Continued From page 18 updated February 28, 2024, noted a review of the facility's policies and procedures related to the provision of home care services and how to implement those policies and procures was required. Documentation of satisfying the in-service training requirement would be retained for each employee performing home care services and the employee would receive verification of the training. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided.	0 650		

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0 650	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 have a written emergency preparedness plan with all the required content and failed to post an emergency	0 680		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 680	Continued From page 20 preparedness plan prominently. This had the potential to affect all eight residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, at approximately 10:35 a.m., during the entrance conference with licensed assisted living director (LALD)-A and house manager (HM)-D, HM-D stated the facilities EPP was in the locked medication closet and posted on the "boards." On November 18, 2024, at 10:41 a.m., during a tour of the facility with LALD-A and HM-D, HM-D pointed to a "board" located behind a door in the inside the facility. The surveyor observed, "Emergency Procedures Fire, Severe Weather and Natural Disasters" in large lettering. Under the lettering was the facilities undated policy: with the same title, posted. The posted policy reviewed the procedures for fire, false alarm, and severe weather/tornados. On November 18, 2024, at 10:45 a.m., LALD-A stated she "thought" the EPP was "more or less" for staff. HM-D stated she was not aware the EPP was to be accessible. HM-D removed the facility's EPP binder from the locked medication closet. HM-D stated she would move the EPP and put it	0 680		

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0 680	Continued From page 21 "there" while she pointed to an unlocked cabinet/shelving area in a common area near the dining room table. The licensee's EPP, dated June 16, 2022, lacked the following content and/or policies and procedures to address: -a risk assessment - a description of the population served by the licensee - process for EPP cooperation with state and local EP officials/organizations - a tracking system used to document locations of residents and staff -missing person policy reviewed quarterly In addition, the licensee lacked a communication plan that included: - a complete list of names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On November 18, 2024, from 12:42 p.m. until 1:22 p.m., the facility EPP was reviewed with LALD-A and HM-D. LALD-A stated the risk assessment was "all done separately, not a one stop shop." LALD-A stated "I am going to say no" to risk assessment done annually as required. LALD-D stated there was no communication plan,	0 680		

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0 680	Continued From page 22 LALD-D added she "thought" they had done one but confirmed there was not a communication plan in the EPP. LALD-A said, we (licensee) had the fire department come out a couple of years ago and they installed these (pointing to something in the kitchen). LALD-A confirmed there was no tracking system for residents and on-duty staff. HM-D stated she was not aware the missing person policy needed to be reviewed quarterly. LALD-A and HM-D confirmed they (licensee) had not fully developed and implemented the facility's emergency preparedness plan/program. On November 19, 2024, at 12:06 p.m., LALD-A stated she was looking on-line and found some EPP risk assessment samples and thought to herself, "that is what she [surveyor] is talking about." LALD-A stated the facility did not have a completed risk assessment as required or a risk assessment that was completed annually. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal 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.	0 680		

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0 680	Continued From page 23 The licensee's Emergency Action Plan dated June 16, 2022, noted the program administrator would conduct an annual review to assess the plan's effectiveness. The review would consider the following: -any newly identified hazards or threats -changes in facility processes or layout -lessons learned from drills and/or tabletop exercise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 780	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on November 20, 2024, from 10:45 a.m. to 12:15 p.m., with housing manager (HM)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC): DOOR LOCKS There were security chain locks installed near the door head jamb in addition to the door latch handle and lock on the two marked exit doors at the end of the resident room corridors. The surveyor explained that marked exit doors are required to open for exit purposes in one operation and the additional security chain	0 780		

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0 780	Continued From page 25 second lock shall be removed in accordance with MSFC Sections 1104 and 1010. EXIT/ EMERGENCY LIGHTS The emergency lighting and exit lights were tested and did not operate upon activation of the test button. The surveyor explained to HM-D, that emergency lighting is required to be maintained and provide light to the exit path in the event of a power loss in accordance with MSFC Section 1104. The surveyor also explained exit lights are required to be maintained and provide continuous lighting of the exit sign in the event of a power loss in accordance with MSFC Section 1104. POWER STRIPS There were power strips daisy chained (power strip plugged into another power strip) in resident sleeping room eight. The daisy chained power strips were providing power to a space heater, mini refrigerator and a popcorn popper and several other smaller electric powered devices. The surveyor explained to HM-D, that electrical power strips are required to be listed to UL 1363 have overcurrent protection and used according to the manufactures instructions and MSFC Section 604. ELECTRICAL EXTENSION CORDS There was an electrical extension cord routed from the office through the doorway into the hallway and through another closet doorway to provide power to a mini refrigerator and computer	0 780		

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0 780	Continued From page 26 printer. The surveyor explained to HM-D, that electrical extension cords shall not be used as a permanent power source and routed through building elements in accordance with MSFC Section 604. STORAGE IN CRAWLSPACE There was storage observed in the unoccupied crawlspace that is not protected by the fire sprinkler system. The surveyor explained to HM-D, that the crawlspace is not allowed to be used for storage in accordance with MSFC Section 903 and National Fire Protection Association (NFPA) 13R. SMOKE ALARM MAINTENANCE There was a smoke alarm hanging by the wires on the wall in resident sleeping room four. The surveyor explained to HM-D, that smoke alarms are required to be maintained in accordance with MSFC Section 901. LIGHT FIXTURE COVERS The was an electrical light fixture cover missing in the large bathroom across the hall from the employee bathroom. The surveyor explained light fixtures are required to be maintained with all covers in accordance with manufactures instructions and MSFC Section 604. During the facility tour HM-D, verified the above	0 780		

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0 780	Continued From page 27 listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 810	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 20, 2024, at 10:10 a.m., housing manager (HM)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated February 2023, failed to include the following: The location and number of resident sleeping rooms were not visibly identified on the posted FSEP evacuation floor plan. The numbers and other text were provided on evacuation floor plan, but it was not legible.	0 810		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 810	Continued From page 29 The surveyor explained to HM-D, that resident sleeping room numbers are required to be included on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on November 20, 2024, at 10:25 a.m., HM-D, stated the above requested documentation was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by providing documentation for one employee and only at time of hire. During an interview on November 20, 2024, at 10:25 a.m., HM-D, stated the above requested training documentation was not available. DRILLS	0 810		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 810	Continued From page 30 Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed during the day shift only. During an interview on November 20, 2024, at 10:25 a.m., HM-D, stated the facility has two shifts and documentation was not available for evacuation drills completed during the second shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or	0 920		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 920	Continued From page 31 services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2) with records reviewed. This had the potential to affect all eight 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: On November 18, 2024, at approximately 10:35 a.m., during the entrance conference licensed assisted living director (LALD)-A stated the same contracts were used for all residents at the facility. R2's diagnoses included generalized anxiety disorder, hypertension (high blood pressure), diabetes, and insomnia. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and	0 920		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 920	Continued From page 32 monitoring/management of behaviors. R2's undated care plan, identified as part of the service plan, indicated R2 received assistance with dressing, peri care, toileting, bathing, nail care, and ambulation. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's signed assisted living contract dated April 19, 2023, lacked the following content: -a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On November 19, 2024, at 12:09 p.m., LALD-A stated she was not aware the assisted living contract required a dementia discloser. LALD-A confirmed the contracts used by the licensee did not have the required information. On November 19, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-C stated all the contracts used by the licensee were the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 950	Continued From page 33 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for the residents to identify or decline a designated representative for one of one resident (R2). This had the potential to affect all eight 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	0 950		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 950	Continued From page 34 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: On November 18, 2024, at approximately 10:35 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the same contracts were used for all residents at the facility. R2's diagnoses included generalized anxiety disorder, hypertension (high blood pressure), diabetes, and insomnia. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors. R2's undated care plan, identified as part of the service plan, indicated R2 received assistance with dressing, peri care, toileting, bathing, nail care, and ambulation. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personal (ULP)-B administer R2's morning medication. R2's signed assisted living contract dated April 19, 2023, included: -designated representative (name/contact) (lines/four names and phone numbers) -IF resident declines to name a Designated Representative, Resident please initial here (line/blank).	0 950		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 950	Continued From page 35 R2's signed assisted living contract lacked the following content: -the required statutory language to identify a designated representative and an opportunity to decline to name a designated representative. On November 19, 2024, at 10:57 a.m., clinical nurse supervisor (CNS)-C stated all the contracts were the same. On November 19, 2024, at 11:06 a.m., the surveyor reviewed the required information with LALD-A. LALD-A noted the requirement location in her regulation book. LALD-A said the contracts used by the licensee did not contain the required content. LALD-A stated she was not aware of the wording required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the	01420		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01420	Continued From page 36 registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide necessary written instructions in the resident record for delegated tasks for one of one resident (R2) for PRN (as needed or desired) wound care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included pressure ulcer of left buttock, stage one, (wounds that develop once a pressure injury causes blood circulation to be cut off from a particular area of the body causing damage to affected tissues, if caught very early and treated properly, these sores can heal in a matter of days. If left untreated, severe bedsores may require years to heal) hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors.	01420		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01420	Continued From page 37 R2's undated care plan, identified as part of the service plan, indicated R2 received assistance with dressing, peri care, toileting, bathing, nail care, and ambulation. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personal (ULP)-B administer R2's morning medication. R2's medication administration record (MAR) dated November 1, 2024, through November 18, 2024, included: -Duoderm CGF 2.5 " x 2.5 " PRN (Duoderm dressing - hydrocolloid dressing, gel-forming agent in an adhesive compound combined with a flexible, water-resistant outer layer used for wounds). R2's prescriber's order dated September 3, 2024, included: -D/C (discontinue) Duoderm, and current orders for buttocks. R2's record did not include instructions for the delegated task of PRN Duoderm. On November 19, 2024, at 9:33 a.m., clinical nurse supervisor (CNS)-C reviewed R2's MAR with the surveyor. CNS-C reviewed R2's prescriber's order for Duoderm also. CNS-C stated R2's PRN Duoderm was a delegated task and stated R2's record did not include information regarding the use of Duoderm and what and when to report issues to RN (registered nurse/CNS-C.) The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated January 2014, noted a registered nurse (RN) may	01420		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01420	Continued From page 38 delegate nursing services to unlicensed staff only after: -including written instructions for performing the procedure for the client (residents) in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01440	Continued From page 39 by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel ([ULP]-B, ULP-G), and one of one house manager (HM)/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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on February 7, 2024, to provide direct care services to the facility's residents. On November 19, 2024, at 8:57 a.m., the surveyor observed ULP-B administer R2's morning medication. ULP-B's employee record included Notes on Supervision of Unlicensed Personnel dated February 8, 2024. On November 19, 2024, at 8:38 a.m., clinical nurse supervisor (CNS)-C reviewed ULP-B's file with the surveyor. CNS-C said she first does a baseline Notes on Supervision [form] with ULPs prior to their training. CNS-C stated ULP-B's employee file did not include a 30-day supervision	01440		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01440	Continued From page 40 form, ULP supervision completed 30 calendar days after the date ULP-B began providing delegated tasks as required. ULP-G ULP-G was hired on July 1, 2024, to provide direct care services to the facility's residents. On November 20, 2024, at 8:47 a.m., the surveyor observed ULP-G prepare and administer R7's morning medication. ULP-G's employee record did not include a supervision form completed within 30 calendar days after the date on which ULP-G began providing delegated tasks as required. On November 19, 2024, at 8:34 a.m., CNS-C stated she did an initial supervision for ULP-G when ULP-G was first hired to check for "baseline." CNS-C stated she did not remember if she ever went back to complete a 30 day supervision for ULP-G. CNS-C reviewed ULP-G's employee file and stated she completed an initial "one" on July 2, 2024, but added did not complete a 30 day supervision visit as required HM/ULP-D HM/ULP-D was hired on January 10, 2024, to provide over site to the licensee's staff and was trained to provide direct care services to the facility's residents. On November 20, 2024, at 12:27 p.m., the surveyor observed HM/ULP-D go outside and light a cigarette for R8 and stay with him while he smoked. On November 19, 2024, at 8:38 a.m., CNS-C stated HM/ULP-D was trained to administer	01440		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01440	Continued From page 41 medication. CNS-C added HM/ULP-D did not administer medication very often. On November 19, 2024, at 8:47 a.m., CNS-C said a 30-day supervision form had not been completed for HM/ULP-D. On November 19, 2024, at 9:55 a.m., CNS-C stated she was aware she was to complete 30-day supervision visits. CNS-C confirmed 30-day supervision non-completion was a widespread issue at the facility. The licensee's Supervision of Licensed and Unlicensed Personnel policy updated February 28, 2024, noted direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and had been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living;	01560		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01560	Continued From page 42 (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. 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: On November 19, 2024, at 11:06 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to provide to consumers. LALD-A stated she was not aware of the requirement.	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01560	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
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 the RN completed ongoing resident reassessments and	01620		

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01620	Continued From page 44 monitoring not to exceed 90 days from previous assessment for two of two residents (R2, R4). Further, the licensee failed to ensure a smoking assessment was completed for R8. In addition, the licensee failed to ensure a registered nurse (RN) conducted assessments with a uniform assessment tool that included all required assessment area content. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses include generalized anxiety disorder, hypertension (high blood pressure), diabetes, and insomnia. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors. R2's undated care plan, identified as part of the service plan, indicated R2 received assistance with dressing, peri care, toileting, bathing, nail care, and ambulation. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B	01620		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01620	Continued From page 45 administer R2's morning medication. R2's record included a 90-day assessment dated December 18, 2023, and March 28, 2024, (101 days from last assessment, 11 days late). R2's record included a 90-day assessment dated June 30, 2024, (94 days from last assessment, four days late). On November 19, 2024, at 10:04 a.m., R2's assessments were reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated, I was thinking June...July... August. I did not think to count the days in each month. CNS-C confirmed R2's 90-day assessments and other resident's 90-day assessments were not completed as required. R4 R4's diagnoses include dementia. R4's Service Plan and Contract dated October 23, 2024, indicated R4 received assistance with administration of medication. On November 19, 2024, at 7:22 a.m., the surveyor observed ULP-B administer R4's morning medication. R4's record included 90-day assessments dated June 30, 2024, and September 30, 2024, (92 days from last assessment, two days late). On November 19, 2024, at 10:46 a.m., R4's assessments were reviewed with CNS-C. CNS-C stated she was aware R4's 90-day assessments were completed later than required. CNS-C added, she was not going to lie about it [late assessments]. CNS-C said it was good to learn assessments could be done earlier than 90 days.	01620		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01620	Continued From page 46 SMOKING ASSESSMENT R8 R8's diagnosis included bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings), migraines, and stenosis of right vertebral arteries (blood supply to the brain narrowed by plaque.) R8's Service Plan and Contract dated November 15, 2024, indicated R8 received medication administration, well-being checks through the day, housekeeping services, 24-awake staff, and leisure activities. On November 20, 2024, at 12:27 p.m., the surveyor observed house manager (HM)/ULP-D go outside and light a cigarette for R8 and stay with him while he smoked. R8's care plan dated November 15, 2024, included: - smoking: cigarettes & lighter is locked in medication drawer - frequency: when requested - provided by caregiver to light and supervise. On November 19, 2024, at 9:15 a.m., CNS-C stated she was not aware a smoking assessment was required. CNS-C sated she marked that R8 smoked on R8's plan of care. HM/ULP-D added R8 does not go out there (outside) by himself to smoke. HM/ULP-D stated R8 can't light a cigarette himself. CNS-C stated she was unaware a smoking assessment was required. UNIFORM ASSESSMENT TOOL On November 19, 2024, at 10:08 a.m., the Resident Summary assessment tool dated July 2020, used at the facility was reviewed with	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01620	Continued From page 47 CNS-C. CNS-C stated the licensee's assessment did not include sleep, dietary, social, spiritual and cultural preferences, allergies reviewed on the assessment, no hydration or elopement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Pre-Assessment and Monitoring-Nursing policy dated November 23, 20222, noted RN will complete a clinical assessment every 90 days after the resident is admitted and/or with all hospital returns and significant changes requiring added services. Reassessments cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01640	Continued From page 48	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two residents (R2) service plan was revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01640	Continued From page 49 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 localized edema, generalized anxiety disorder, hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors. R2's undated Care Plan, identified as part of the service plan, included: Ted socks (compression stockings) N/A. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's prescriber order dated November 6, 2024, included: -knee length compression stockings, on in a.m. (morning), off at bedtime. R2's medication administration record (MAR) dated November 1, 2024, thorough November 17, 2024, included: -tubigrip (compression stockings) to bilateral lower extremities on in a.m., off at bedtime. R2's service plan had not been revised to include compression stockings. On November 19, 2024, at 9:42 a.m., clinical nurse supervisor (CNS)-C stated R2's service	01640		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01640	Continued From page 50 plan had not been updated as required to include compression stockings. The licensee's undated Contents of Service Plans policy noted the service plan, including each revision is entered into the client's (resident's) record. The service plan is revised and signed by the RN (registered nurse) and/or other licensed health professional and the client and/or the client's representative any time home care services change based on changes in the client's needs or preferences and any time our agency's fee schedule changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01650	Continued From page 51 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (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) 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 diagnoses included localized edema, generalized anxiety disorder, hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors.	01650		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01650	Continued From page 52 On November 19, 2024,at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's service plan lacked: -the methods of monitoring staff providing services -the methods of monitoring residents. On November 19, 2024, at 10:49 a.m., R2's service plan was reviewed with licensed assisted living director (LALD)-A whom stated the licensee's service plan template did not include the method for either (residents or staff) and how often [frequency] of services. LALD-A added some service plans may be also missing frequencies of some services. The licensee's undated Contents of Service Plans policy noted a service plan established after completion of full individualized initial assessment and each subsequent reassessment included: -the frequency of each service, according to the client's (resident's) current assessment and preferences -the schedule and methods of monitoring reviews or re-assessments of the client, including if the method was face to face or via telemonitoring -the frequency of supervision of staff providing services and the identification of the supervisor(s) who would be providing the supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01750	Continued From page 53 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions relating to the administration of medications for three of three residents (R2, R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 R2's diagnoses included localized edema (swelling), hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which	01750		

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01750	Continued From page 54 included medication administration. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. Directly after the above observation, the surveyor reviewed R2's medication administration record (MAR) with ULP-B. ULP-B stated there were no specific instructions in R2's record for insulin administration. R2's prescriber's orders included: - February 20, 2024: Fleets Enema, every 2-3 days PRN (as needed or desired) constipation, give one Fleets enema via rectum in 24 hours: ONLY THOSE WHO HAVE BEEN SPECIFICALLY TRAINED MAY PERFORM THIS TASK. Call a doctor promptly if no liquid comes out of the rectum after 30 minutes as dehydration may occur. Using more than one enema in 24 hours can be harmful, serious side effects may occur. Stop use and ask a doctor if the client (resident) has rectal bleeding, has no bowel movements after enema is given, as these symptoms may indicate a serious condition. Ask a doctor before use if the client has a kidney disease, on a low salt diet, has nausea, vomiting, or abdominal pain, a sudden change in bowel habits lasting more than two weeks, or has already used a laxative for more than one week. - September 3, 2024: start zinc oxide barrier cream (skin protector/moisture), apply to bilateral buttocks BID (twice a day) and BID PRN - October 8, 2024: increase Lantus 100 units/ milliliter (ml) (long-acting insulin) to 28 units subcutaneously (SQ/into fatting tissue) daily - March 19, 2024: Ozempic 1 milligram (mg) (diabetes) once weekly - July 16, 2024: ok to take Metamucil fiber	01750		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01750	Continued From page 55 gummies (bowel health) purchased over the counter, 1-3 gummies by mouth PRN daily. R2's medication administration record dated November 1, 2024, through November 17, 2024, included: -ready to use enema: for Fleet saline rectal enema, insert 1 enema rectally every 24 hours as needed for constipation -zine oxide 20% ointment, 8:00 a.m., 1600 (4:00 p.m.) -Lantus 100 units/ ml for injection, inject 28 units SQ once daily -Ozempic 1 mg dose, inject 1 mg SQ once weekly, on Wednesdays -Metamucil fiber gummies (bowel health), take 1-3 gummies by mouth PRN. R2's MAR did not include: - specific instructions for Fleets enema as written in prescriber's order - location for zinc oxide use as ordered - manufacturer's instruction for injectable medication: site rotation - parameters for number of gummies to be administered. On November 19, 2024, at 9:31 a.m., R2's MAR was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated ULPs were not trained to give enemas. CNS-C stated R2's record did not have direction for zinc oxide placement, as it (MAR) should. CNS-C said she "did not think about it" (range order) for Metamucil fiber gummies, but added it made sense that clear direction was needed. CNS-C said she understood as there is clear direction in MARs at the hospital for medication administration. CNS-C stated R2's MAR did not include specific instructions for R2's insulin/Ozempic	01750		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01750	Continued From page 56 administration, to include site administration. CNS-C added she does not administer insulin in the hospital but said, "you are right" there is a place to document injection site. CNS-C confirmed R2's MAR did not include specific resident instructions as required. The manufacturer's instructions for zinc oxide copyright 1996-2024 noted, use exactly as directed on the label, or as prescribed by your doctor. (MAR lacked location for use). The manufacturer's instructions for Lantus dated August 2022, noted change (rotate) your injection sites within the area you choose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection site. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. The manufacturer's instructions Ozempic dated October 2023, noted, inject SQ to the abdomen, thigh, or upper arm. Instruct patients to use a different injection site each week when injecting in the same body region. R4 R4's diagnoses included dementia. R4's Service Plan and Contract dated October 23, 2024, indicated R4 received medication administration. On November 19, 2024, at 7:22 a.m., the surveyor observed ULP-B hand R4 a Symbicort 160-4 microgram (mcg), inhaler (reduces inflammation in the lungs) and stand by R4 while R4 inhaled the medication twice.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01750	Continued From page 57 R4's prescriber order dated December 12, 2023, included: -start Symbicort 160/4.5 mcg, give 2 puffs BID (twice daily). R4's MAR dated October 1, 2024, through October 31, 2024, included: -Symbicort 160-4 mcg, inhale 2 puffs into lungs twice a day. Rinse mouth after use. On November 19, 2024, at 10:02 a.m., the surveyor and CNS-C reviewed R4's MAR. The surveyor and CNS-C also reviewed the manufacturer's instructions located in the box R4's Symbicort inhaler came in. CNS-C stated R4's MAR did not include the instruction to shake the inhaler prior to use as indicated in the instructions as required. The manufacturer's instructions for Symbicort dated 2018, included if using for the first time, or if you haven't used in more than 7 days, shake your Symbicort inhaler well for 5 seconds, then release a test spray. Shake it again for 5 seconds and release a second test spray. After use, rinse your mouth with water, spit out the water, do not swallow it. R6 R6's diagnoses included dementia. R6's Service Plan and Contract dated January 21, 2023, indicated R6 received medication administration. R6's prescriber order dated November 23, 2021, noted, Lotrisone/clotrimazole (antifungal) 1% cream, one gram, to under right breast and abd (abdomen) folds BID for two weeks then change	01750		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01750	Continued From page 58 to BID, PRN. R6's MAR dated November 1, 2024, through November 18, 2024, included: -clotrimazole/betamethasone, Lotrisone for topical cream, apply one gram amount under right breast and abd folds twice daily for two weeks, PRN. On November 19, 2024, at 6:26 a.m., the surveyor observed ULP-E take R6's clotrimazole ointment to a bathroom. R6 was seated on the toilet. ULP-E with gloved hands cleaned under R6's left abd skin folds, with a moistened washcloth. ULP-E patted the area dry with a clean dry washcloth. ULP-E applied ointment to area and asked R6 if R6 would like a dry cloth placed in R6's abd folds. A clean dry washcloth was placed in R6's abd folds by ULP-E. ULP-E removed gloves, washed hands, and returned R6's ointment to the medication cart. On November 19, 2024, at 9:31 a.m., CNS-C stated ULP-E applied R6's clotrimazole ointment correctly. CNS-C stated R6's MAR should have included specific instructions for the application of R6's clotrimazole ointment. CNS-C confirmed instructions should have included when and what to report to CNS-C. The licensee's Medication Administration policy dated February 1, 2020, noted the RN (registered nurse) had developed written, specific instruction for each resident for administering the medications. The licensee's Content of Medication Prescription Orders updated February 28, 2024, noted if a prescription was incomplete or prescription for a PRN medication or medication with a variable	01750		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01750	Continued From page 59 dosage does not include clear parameters for administration, the RN an/or director would notify the prescriber and obtain the required information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 three employees, (unlicensed personnel (ULP)-E). In addition, the licensee failed to ensure one of three ULP (ULP-B) followed registered nurse (RN) written instructions for the administration of an inhaler for R4. Further, the licensee failed to ensure	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01760	Continued From page 60 medications were administered as ordered for one of three residents (R7) who received medication management services. Additionally, the licensee failed to ensure documentation to include the effectiveness for as needed (PRN) medication administration for one of two residents (R2) was completed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FOLLOWING THE STEPS OF THE MEDICATION ADMINISTRATION PROCESS On November 19, 2024, at 6:26 a.m., the surveyor observed ULP-E ask R6 if she was ready for assistance. The surveyor did not observe ULP-E review R6's medication administration record (MAR). ULP-E removed a tube of clotrimazole ointment (antifungal medication) from the locked medication cart. ULP-E took the ointment to a bathroom. R6 was seated on the toilet. ULP-E with gloves hands cleaned under R6's left abdomen skin folds, with a moistened washcloth. ULP-E patted the area dry with a dry clean washcloth. ULP-E applied ointment to area and asked R6 if R6 would like a dry cloth placed in R6's abdomen folds. ULP-E removed gloves, washed hands, and returned the ointment to the medication cart. ULP-E went to the laundry room. ULP-E asked an unidentified	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01760	Continued From page 61 resident in room numbered two if she wanted to get up (down the opposite hallway.) On November 19, 2024, at 6:38 a.m., ULP-E stated she did look at R6's MAR earlier, during the night. ULP-E said she should have looked at R6's MAR before applying the medication. On November 19, 2024, at 6:40 a.m., ULP-E stated she was going to document R6's ointment "now". ULP-E said she got "distracted." ULP-E added R6 was the only resident that got a medication at that time of the day. ULP-E stated she was trained to first look at the MAR and to document right after medication administration. On November 19, 2024, at 9:51 a.m., CNS-C stated her expectation was ULP document medication after giving the medication. On November 19, 2024, at 9:52 a.m., CNS- C stated ULPs should check the MAR prior to medication administration. FOLLOWING WRITTEN INSTRUCTION R4 R4's diagnoses included dementia. R4's Service Plan and Contract dated October 23, 2024, indicated R4 received medication administration. On November 19, 2024, at 7:22 a.m., the surveyor observed ULP-B hand R4 a Symbicort 160-4 microgram (mcg), inhaler (reduces inflammation in the lungs) and stand by R4 while R4 inhaled the medication twice. R4's prescriber order dated December 12, 2023, included:	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01760	Continued From page 62 -start Symbicort 160/4 mcg, give 2 puffs BID (twice a day). R4's MAR dated October 1, 2024, through October 31, 2024, included: -Symbicort 160-4 mcg, inhale 2 puffs into lungs twice a day. Rinse mouth after use. On November 19, 2024, at 8:19 a.m., the surveyor reviewed R4's MAR with ULP-B. ULP-B read the instructions, "rinse mouth after use." ULP-B stated she did not have R4 rinse her mouth out after using R4's Symbicort inhaler. ULP-B confirmed the written directions on R4's MAR were not followed. On November 19, 2024, at 9:31 a.m., CNS-C and the surveyor reviewed R4's MAR. CNS-C stated instructions on the MAR were to be followed and ULP-B should have had R4 rinse her mouth after the administration of the inhaler. MEDICATION GIVEN AS PRESCRIBED R7 R7's diagnoses included schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions and mood disorder, such as depression or mania). R7's Care Plan dated April 17, 2024, included medication administration. R7's prescriber order dated August 5, 2024, included: -Metamucil powder (bowel health) teaspoon, TID (three times a day). R7's MAR dated October 1, 2024, through October 31, 2024, included the above medication.	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01760	Continued From page 63 On November 20, 2024, at 8:47 a.m., the surveyor observed ULP-G put water into a glass and add one tablespoon of Metamucil powder into it and stir. ULP-G administered the Metamucil powder to R7. On November 20, 2024, at 8:52 a.m., the surveyor and house manager (HM)-D checked the measuring spoon used for R7's Metamucil. HM-D confirmed a tablespoon was used to measure R7's Metamucil medication, not a teaspoon, as on R7's MAR. On November 20, 2024, at 8:56 a.m., ULP-G reviewed R8's MAR with the surveyor. ULP-G stated, "they [licensee] must have changed that [R8's Metamucil order/dosage]." ULP-G confirmed the dose given was incorrect. PRN MEDICATION R2 R2's diagnoses included localized edema, hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. On November 19, 2024, at 8:57 a.m., the surveyor observed ULP-B administer R2's morning medication. R2's prescriber order dated included November 5, 2024, included: -give Artificial tears one drop each eye BID and BID PRN x five days, then QID (four times a day) PRN. R2's MAR dated November 1, 2024, through	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01760	Continued From page 64 November 18, 2024, included: -Artificial tears, one drop each eye four times daily as needed, PRN. R2's Artificial tears was instilled twice a day from November 11, 2024, through November 17, 2024 -two of 14 opportunities, included medication use, reason and outcome. On November 19, 2024, at 9:21 a.m., CNS-C stated her expectation was every time a PRN was given "you" (ULP) document why and "did it (medication) help." CNS-C stated ULPs did not document PRN use as required. The licensee's undated Documentation of Medication Administration policy noted assistance with medications and medication administration would be documented immediately on the resident's paper MAR after completion of the task, according to the home care licensing requirements and professional standards of documentation. Further, Staff will administer PRN medications exactly as prescribed and will document administration medications immediately after administration. The RN (registered nurse) would include indications and specific instructions for PRN medications so that competency trained unlicensed staff can determine whether or not the medication should be given. The RN would review administered medications and their effectiveness. When documenting a PRN medication, you must list the reason the medication was requested i.e. anxiety, insomnia, pain (include location and 1-10 pain scale). Follow up on the PRN medication must be completed in one hour after administration. The licensee's Medication Administration policy dated February 1, 2020, noted unlicensed	01760		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 65 personnel that would provide assistance with medication administration will be trained and competency tested by the RN on the following: -the complete procedures for checking the resident's medication administration record and medication profile, preparation of the medication for the resident, when necessary, administration of the medication to the resident, documentation after assistance with self-administration of medications or medication administration, consistent with our agency's procedures for documenting the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (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	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01770	Continued From page 66 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: R2's diagnoses included diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. R2's undated Care Plan included: -Lantus (long-acting insulin/diabetes) 30 units, caregiver RN (registered nurse) set-up for Lantus. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's prescriber order dated October 8, 2024, included: -increase Lantus to 28 units subcutaneously (SQ) daily. R2's medication administration record (MAR) dated November 1, 2024, through November 17, 2024, included: -insulin fill, 8-day supply - *RN (registered nurse) only This entry included: clinical nurse supervisor (CNS)-C's initials on November 8, 2024, and November 16, 2024. And -Lantus 100/units/milliliter (ml) for injection, inject 28 units, SQ, once daily, 8:00 a.m., -initials of ULPs who administered R2's Lantus.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01770	Continued From page 67 On November 18, 2024, at 11:54 a.m., the surveyor and licensed assisted living director (LALD)-A reviewed R2's MAR. LALD-A stated R2's MAR included the required information for R2's insulin administration. The surveyor reviewed the Minnesota 144G Statutes guide with LALD-A. LALD-A confirmed R2's set up for "insulin" included the date the syringes were filled, how many were filled, and CNS-C's initials. LALD-A stated R2's medication set up record did not include required information to include the name of the medication, dose of the medication, route to be administered and time to be administered. On November 19, 2024, at 9:23 a.m., CNS-C stated she did not think about it, [medication set up MAR entry]. CNS-C added that was how it [medication set up information] was always completed. On November 19, 2027, at 9:27 a.m., CNS-C stated all medications need to have the correct information on the label, and stated she would change the process used. The licensee's Medication Set Up and/or Verification policy dated January 1, 2024, noted the following procedure would be followed for medication set-up under the medication administration system. The RN (registered nurse) would: Transcribe medication prescription onto the resident's medication profile This profile would included: a. medication name and strength b. dosage of medication c. day and time of administration d route of administration e. indication f. any specific instructions for administering the	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01770	Continued From page 68 medication to the client (resident). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of one resident (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included generalized anxiety disorder, hypertension (high blood pressure/HTN), diabetes, and insomnia.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01820	Continued From page 69 R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personal (ULP)-B administer R2's morning medication. R2's medication administration record (MAR) dated November 1, 2024, through November 17, 2024, included: -metformin 1000 milligrams (mg) (diabetes), take one tablet twice daily -aspirin 81 mg (heart health), take one chewable tablet daily -atenolol 100 mg (HTN), 100 mg daily. R2's record did not include prescriber orders for: -metformin 1000 mg, two times daily -aspirin chewable 81 mg, one time a day -atenolol 100 mg daily. On November 19, 2024, at 11:23 a.m., clinical nurse supervisor (CNS)-C stated she was not aware SNF (skilled nursing facility) orders (inter-agency forms) could not be used as prescriber's orders for assisted living facilities. CNS-C stated R2 was admitted from (name/SNF). CNS-C added the process was; a nurse practitioner (NP) came in [to facility], completed resident admission, and ordered medication for resident. CNS-C said if the licensee received prescriber's orders for medications the prescriber's orders should be in the resident records. CNS-C stated all of R2's medication orders were not in R2's record. CNS-C confirmed this would be a widespread issue. The licensee's Content of Medication Prescription	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01820	Continued From page 70 Orders policy dated February 28, 2024, noted a current, written or electronically recorded prescriber's order must be obtained for any mediation, including an over-the counter medication or dietary supplement, which our agency was managing for the resident. A medication prescription must include: -the date of issue -name and address of the resident -name and quantity of the drug prescribed -dosage and any specific directions for use -name, address and telephone number where the prescriber could be reached -the prescriber's manual or electronic signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (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	01830		

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01830	Continued From page 71 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: R2's diagnoses included generalized anxiety disorder, hypertension (high blood pressure/HTN), diabetes, and insomnia. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's medication administration record (MAR) dated November 1, 2024, through November 18, 2024, included: - venlafaxine 150 milligrams (mg), daily (depression) - venlafaxine 37.5 mg, daily - vitamin B12 1000 micrograms (mcg), daily (supplement) - vitamin D3 5000 units daily, (supplement) - hydrochlorothiazide 12.5 mg, daily, (HTN) - amlodipine 10 mg, daily (heart) - allopurinol 100 mg, daily (gout, a form of arthritis) - lisinopril 40 mg, daily (heart) R2's record included the following prescriber's orders: - increase venlafaxine to 150 mg and 37 mg daily, to equal 187.5, dated October 31, 2023 - give vitamin B12 1000 mcg daily, dated	01830		

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01830	Continued From page 72 September 20, 2023 - give vitamin D3 5000 units daily, dated September 20, 2023 - start hydrochlorothiazide 12.5 mg daily, dated September 28, 2023 -start amlodipine 10 mg daily, dated July 6, 2023 - start allopurinol 100 mg daily, dated July 20, 2023 - start lisinopril 40 mg daily, dated September 28, 2023. On November 19, 2024, at 9:42 a.m., the surveyor reviewed R2's provider's orders with clinical nurse supervisor (CNS)-C. CNS-C stated she did not see the above list of medication orders in R2's record. CNS-C stated she did not know she needed to have current prescriber's orders in resident records. CNS-C said, she assumed the provider (nurse practitioner/NP) faxed the medication list in [to pharmacy] monthly. On November 20, 2024, at approximately 12:45 p.m., the surveyor stated if the licensee found the orders for the above medication for R2 from the NP to email them to the surveyor. On November 25, 2024, at 8:43 a.m., the surveyor received an email from house manager (HM)-D with R2's prescriber's order. The email did not contain annual orders for the above listed medications. The Requesting and Receiving Prescriptions and Refills policy dated January 1, 2020, noted the RN (registered nurse) or director would assure that the prescriber renews a medication prescription at least every 12 months, or more frequently if determined necessary based on the nursing assessment Signed annual MD (medical	01830		

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01830	Continued From page 73 doctor) orders will meet this criterion. To keep orders up to date, whenever possible, the RN or director would provide the resident with a list of current orders to take to any physician appointments or will fax the list of current orders to the physician's office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored during the medication administration process by one of three unlicensed personnel (ULP)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01880		

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01880	Continued From page 74 On November 19, 2024, at 7:33 a.m., the surveyor observed ULP-B prepare R7's morning medication. ULP-B closed the medication cart and closed the medication closet door and walk down the hallway. The surveyor observed two residents, R7 and R6, sitting in the open common's area. The surveyor did not observe ULP-B lock the medication cart or the medication closet door. On November 19, 2024, at 7:34 a.m., the surveyor asked house manager (HM)-D if the medication cart and/or medication closet door should be unsecured. HM-D added ULP-B should have locked the door. HM-D locked the medication cart and the medication closet door. On November 19, 2024, at 7:36 a.m., ULP-B stated she thought she locked the cart/door. ULP-B said the medication cart/door should be locked. On November 19, 2024, at 9:53 a.m., clinical nurse supervisor (CNS)-C stated the door, or the medication closet should be locked when a staff is not present. CNS-C added she preferred both be locked when not in use. The licensee's Storage of Medications policy updated February 28, 2024, noted: - for senior housing settings where medications were delivered for multiple clients: when clients are living in a housing-with-services establishment or similar senior housing setting the RN would develop a procedure to secure medications when they were delivered to the building rather than delivered directly to the client in the client's living space. (for example, the pharmacy puts the medications directly into a	01880		

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01880	Continued From page 75 locked area accessible only by the nurse: or the pharmacy delivers only when the nurse is on-site to receive them (medications). For senior housing settings where medications are managed by the agency, the RN would establish a system that addresses the storage and handling of medications, including: -how medications would be received and secured when delivered by the pharmacy -where medications would be stored -how medications would be secured if in the client's private living space or if centrally stored -who is authorized to access the medications -how refills and prescription renewals would be monitored -controls and procedures to identify or prevent diversion of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing legible information including the opened-on date for time sensitive	01890		

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01890	Continued From page 76 medication for R4, R3, R2. The licensee failed to ensure information was legible, complete, and correct for R4, R2, R3. In addition, the licensee failed to monitor for expired medication for R5. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 18, 2024, at 10:50 a.m., the surveyor reviewed the contents of the locked medication cart with unlicensed personnel (ULP)-B. ULP-B observed and confirmed the following: TIME SENSITIVE MEDICATION -opened Symbicort (asthma) 160/4.8 micrograms (mcg) inhaler, in R4's medication cubby, lacked the date the inhaler was opened or expiration date -R3's opened timolol maleate (high eye pressure) 0.5% eye solution did not have an open date or expiration date -R2's Lantus insulin (long acting/diabetes) seven pre-filled, 28 units syringes lacked to include open date or expiration date. CORRECT INFORMATION -R3's timolol maleate 0.5% eye solution was in a plastic bag labeled hydrocortisone 1% (topical medication that reduces inflammation) ointment, apply topically BID (two times daily) for R3.	01890		

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01890	Continued From page 77 PRESCRIPTION LABEL -R4's Symbicort inhaler lacked the original prescription label with legible information. ULP-B stated she "knew" that was R4's as it was in R4's cubby and on R4's medication administration record (MAR). ULP-B stated she was unable to locate the plastic bag or box R4's inhaler had been in -R3's timolol eye solution lacked the original prescription label with legible information -R2's Lantus insulin, seven, 28 units syringes lacked to include time of administration, and route of administration. LEGIBLE INFORMATION -R2's opened Lantus 100 units/ml vial lacked to include a legible open and expiration date. Directly after the above observation, licensed assisted living director (LALD)-A and house manager (HM)-D stated they were not able to read R7's Lantus vial date open or expired. HM-D said maybe clinical nurse supervisor (CNS)-C knew the date. On November 18, 2024, at 11:22 a.m., ULP-B stated, "I see that" in regard to R4's timolol eye solution being in the wrong plastic bag. ULP-B was not able to locate the correct bag for R4's timolol eye solution. ULP-B said R2's Lantus syringes did not include the route, pharmacy, or time of administration. On November 19, 2024, at approximately 9:00 a.m., CNS-C stated she corrected R2's insulin. EXPIRED MEDICATION -R5's Fluticasone propionate (allergies) 50 mcg had an expiration date November 17, 2024.	01890		

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01890	Continued From page 78 On November 19, 2024, at 10:02 a.m., the surveyor and CNS-C reviewed the locked medication cart. CNS-C stated medications should be labeled correctly. The surveyor and CNS-C reviewed the insert from R4's Symbicort inhaler regarding expiration date. ULP-B told CNS-C the baggy "went missing" for R3's timolol eye solution and added the timolol medication was "tossed" [discarded]. The manufacturer's instructions for Symbicort dated July 2019, noted it is important that you pay attention the number of inhalations (puffs) left in your Symbicort inhaler by reading the counter. Throw away Symbicort when the counter shows zero or three months after you take your Symbicort inhaler out of its foil pouch, whichever comes first. The manufacturer's instructions for Timolol dated February 2020, noted discard the bottle 28 days after opening, even if there is solution remaining. The manufacturer's instructions for Lantus insulin vials dated March 2024, noted once you start using a new Lantus multiple dose vial you should discard it after 28 days. The licensee's Storage of Medications policy updated February 28, 2024, noted until the medication was set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time dated drug, directions for use, client's (resident's) name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued	01890		

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01890	Continued From page 79 the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.	01930		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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01930	Continued From page 80 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at 10:23 a.m., assisted living director (LALD)-A and house manager (HM)-D stated the licensee provided treatment and therapy management services to the licensee's residents. The licensee lacked policies and procedures that addressed: - educating and communicating with residents about treatments or therapies they are receiving. - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On November 20, 2024, at 10:43 a.m., clinical nurse supervisor (CNS)-C confirmed the licensee did not have the required policy, adding she was aware many of the policies required were outdated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days formation was provided.	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 81 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) who had treatments managed by the facility.	01940		

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01940	Continued From page 82 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 localized edema, generalized anxiety disorder, hypertension (high blood pressure), and diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, and monitoring/management of behaviors. R2's undated Care Plan included: -Ted socks (compression stockings) N/A. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's Treatment and Therapy Management Plan dated April 19, 2023, included: -PT (physical therapist) for continued strengthening, balance, endurance, ambulation, and ADLs (activities of daily living.) -OT (occupational therapist) for continued strengthening, balance, endurance, ambulation, and ADLs (activities of daily living.) -blood glucose three times daily, 8:00 a.m., 12:00 p.m., 2000 (8:00 p.m.).	01940		

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01940	Continued From page 83 R2's prescriber order dated November 6, 2024, included: -knee length compression stockings, on in a.m., off at bedtime. R2's medication administration record (MAR) dated November 1, 2024, thorough November 17, 2024, included: -tubigrip (compression stockings) to bilateral lower extremities on in a.m., off at bedtime. R2's record did not include a statement of the type of service being provided, compression stockings. On November 19, 2024, at 9:41 a.m., the surveyor reviewed R2's treatment plan and service plan with clinical nurse supervisor (CNS)-C. CNS-C stated R2's record did not have a written statement that the service of compression stockings application was being provided. CNS-C added she hoped that with the addition of a computer system these types of errors would be corrected. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks policy dated January 1, 2014, noted treatments or therapy tasks may be delegated or assigned by a licensed health professional to unlicensed personnel according to the licensed health professional's applicable licensing practice standards. When a treatment or therapy is delegated or assigned to unlicensed personnel, the RN (registered nurse) or authorized licensed health professional must: -develop and maintain a current individualized treatment or therapy management record for each client that addresses the requirements of	01940		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01940	Continued From page 84 MN Statutes 144.4793, Subd. 3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R2, R3) receiving treatments.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01950	Continued From page 85 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 R2's diagnoses included diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. R2's undated Care Plan indicated R2 received Accu-Checks (blood glucose monitoring) one time daily. R2's prescriber order dated May 11, 2023, included: -reduce glucose checks to one daily in the a.m., (morning/fasting blood glucose). R2's prescriber order dated November 6, 2024, included: -knee length compression stockings, on in a.m. (morning) off at bedtime. R2's medication administration record (MAR) dated November 1, 2024, through, November 18, 2024, included: -True Metrix (brand) glucose test, test BS (blood glucose) one time daily -Tubigrip (compression stockings) to bilateral lower extremities on in a.m., off at bedtime.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01950	Continued From page 86 On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's oral medication and document R2's oral medication as administered. The surveyor reviewed R2's MAR with ULP-B. ULP-B stated there were no specific instructions in R2's record for blood glucose monitoring or for R2's compression stockings. On November 19, 2024, at 9:41 a.m., clinical nurse supervisor (CNS)-C stated she did not think about including specific instructions in R2's record for compression stockings or for blood glucose. CNS-C added this type of nursing was newer to her. CNS-C said it made sense to have specific instructions in resident records. R3 R3's diagnoses included diabetes. R3's Service Plan and Contract dated October 29, 2024, indicated R3 received assistance with Accu-checks (blood sugar checks/monitoring) daily. On November 19, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-B check R3's blood sugar level using correct technique. R3's MAR dated November 1, 2024, though November 18, 2024, included: -check blood sugar daily in the morning before breakfast R3's prescriber order dated November 14, 2024, included: -Accu check Aviva (brand name) plus test strips to use three times daily.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

(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
01950	Continued From page 87 On November 19, 2024, at 9:29 a.m., clinical nurse supervisor (CNS)-C stated she was not aware that parameters for blood glucose were required on R2's and R3's MAR. CNS-C added, it makes sense to do. The licensee's Applying Compression Stockings/Support Hose policy dated January 1, 2014, noted obtain stockings. Check care plan for any specific client (resident) instructions. The licensee's Delegation of Nursing Tasks, Treatments or Therapy Tasks dated January 2014, noted steps prior to delegating administration of treatments and therapy included: -develop written specific instructions for each client and document those instructions in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01960	Continued From page 88 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for one of two residents (R3) with health monitoring managed by the provider. 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: R3's diagnoses included diabetes. R3's Service Plan and Contract dated October 29, 2024, indicated R3 received assistance with Accu-checks (blood sugar checks/monitoring) daily. On November 19, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-B check R3's blood sugar level using correct technique. R3's prescriber order dated November 14, 2024, included: -Accu check Aviva (brand name) plus test strips to use three times daily. R3's MAR dated November 1, 2024, through November 18, 2024, included:	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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01960	Continued From page 89 -check blood sugar daily in the morning before breakfast. On November 20, 2024, at 10:40 a.m., R3's prescriber order was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated that is "problematic," [order for R3's blood sugar checks three times a day and on MAR once daily]. CNS-C stated she did not" see that", "I saw testing strips." CNS-C stated, "that is on me" [error]. CNS-C stated she should have sought clarification, and the order should have been verified. CNS-C stated she heard once a day [blood sugar monitoring]. The licensee's Content of Medication Prescription Orders policy dated February 28, 2024, noted to ensure complete and up-to date medication prescriptions, treatment and therapy order for each resident are received from an authorized prescriber. If a prescription is incomplete or a prescription for a PRN (as needed or desired) mediation or medication with a variable dosage does not include clear parameters for administration, the RN (registered nurse) and/or director will notify the prescriber and obtain the required information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a	01970		

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	30619	A. BUILDING: _____ B. WING _____	11/20/2024

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01970	Continued From page 90 description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R2) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at, at 10:23 a.m., licensed assisted living director (LALD)-A and house manager (HM)-D stated the licensee provided treatment/therapy management services to the residents at the facility. R2's diagnoses included diabetes. R2's Service Plan and Contract dated June 20, 2023, indicated R2 received services which included medication administration. R2's undated Care Plan indicated R2 received	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 91 Accu-Checks one time daily. On November 19, 2024, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-B administer R2's morning medication. R2's prescriber order dated May 11, 2023, included: -reduce glucose checks to once daily in the a.m., (morning/fasting blood glucose). R2's medication administration record (MAR) dated November 1, 2024, through, November 18, 2024, included: -True Metrix (brand) glucose test, test BS (blood glucose) one time daily. On November 19, 2024, R2's prescriber order for blood glucose monitoring was reviewed with CNS-C. The surveyor did not observe a yearly order for R2's BS monitoring. CNS-C stated there was an order for R2's blood glucose monitoring but stated there was not a recent/ yearly order. CNS-C stated she was not aware the licensee was required to have annual orders. The licensee's Content of Medication Prescription Orders updated February 28, 2024, noted a current, written or electronically recorded prescriber's order must be obtained for a treatment or therapy to be provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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02320	Continued From page 92 (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 medication administration process was completed as instructed by one of one employee, (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 20, 2024, at 8:28 a.m., the surveyor observed ULP-G preparing R8's medication. ULP-G commented R8 was the last medication administration for the morning. ULP-G stated she had completed everyone's (resident's medication administration) earlier. ULP-G locked the medication room door and the surveyor observed two medication cups in ULP-G's hand. ULP-G went to R8's side and asked him if he had anything to drink. ULP-G handed R8 one of the medication cups and watched R8 take the oral	02320		

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02320	Continued From page 93 medication. On November 20, 2024, at 8:31 a.m., ULP-G took the second medication cup and handed the medication cup to R3. ULP-G confirmed she had prepared and left the medication room with two medication cups, for two residents, R8, R3. On November 20, 2024, at 8:39 a.m., ULP-G stated she first set up R3's medication. ULP-G said she also set up R8's medication, adding R8 wanted to go outside to smoke and R8 only had three oral medications. ULP-G stated that is not how she learned in "school or was taught by the registered nurse (RN). ULP-G said she knew R8's only had three medications she could tell which medication cup belonged to who. On November 19, 2024, at 9:51 a.m., clinical nurse supervisor (CNS)-C stated you (ULP) looks at the MAR, document after medications were given and one client (resident) is done at a time. CNS-C said, "it is one give, and stand there and sign [document.] On November 20, 2024, at 10:49 a.m., CNS-C shook her head and said, "no, no, no" medications are to be given one at a time, "we do not set up medications." ULP-G's employee record included: - skills/competency test of administration of oral medication completed July 2, 2024. - medication administration- overview/routes on-line training completed on July 3, 2024. On November 20, 2024, at 9:05 a.m., house manager (HM)-D stated she was not sure why on-line training was completed for ULP-G after medication competency.	02320		

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02320	Continued From page 94 The licensee's Medication Administration policy dated February 1, 2020, noted unlicensed personnel that will provide assistance with medication administration would be trained and competency tested by the RN on the following: -the complete procedures for checking the resident's medication administration record and medication profile. Medications always need to be administered according to the "7 rights." 1. right person 2. right medication 3. right time/day 4. right route (by mouth, eye drops, to the skin, etc.) 5. right dose (how many milligrams, drops, etc) 6, right chart/record to document the medication was taken 7. right to refuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *11/19/24*
Time: 10:30:00
Report: 1027241152

Food and Beverage Establishment Inspection Report

Location:
Plainview Estates
2507 Fairview Avenue
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0039260
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/25

Operator:

Phone #: 2188798230
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW GROUND BEEF WAS BEING STORED OVER READY TO EAT FOODS SUCH AS LETTUCE IN UPRIGHT COOLER. STAFF MOVED GROUND BEEF TO A LOWER LOCATION. COS

Corrected on Site

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

CONTAINERS OF POWDERED SUGAR AND BROWN SUGAR WERE MISSING LABELS.

Comply By: 11/19/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at >160F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *11/19/24*
Time: 10:30:00
Report: 1027241152
Plainview Estates

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: EGGS
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: BEEF STEW
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027241152 of 11/19/24.

Certified Food Protection Manager: TRACY ELDER

Certification Number: FM86959 Expires: 12/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
TRACY ELDER
MANAGER

Signed: Ian Harrison
Ian H

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

Report #: 1027241152

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	11/19/24
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Plainview Estates	2507 Fairview Avenue	Cloquet, MN	55720	2188798230

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039260		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	(OUT)	N/A	N/O	Food separated and protected	X	
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	(IN)	OUT	N/A	N/O	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37	X	Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/19/24

Inspector (Signature) Dan Harrison