Electronically Delivered

July 24, 2025

Licensee
Majestic Pines Senior Living
1614 Golf Course Road
Grand Rapids, MN 55744

RE: Project Number(s) SL30986016

Dear Licensee:

On June 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 3, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin Zwart

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

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April 30, 2025

Licensee
Majestic Pines Senior Living
1614 Golf Course Road
Grand Rapids, MN 55744

RE: Project Number(s) SL30986016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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 Majestic Pines Senior Living. **Please contact Jessie Chenze at 218-332-5175 on or before Monday, May 5, 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

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
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL3098016 On March 31, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 94 residents: 90 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of facility space by a vendor to provide therapy services to residents and to outside community members. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 9:00 a.m., the surveyor entered the assisted living facility, through an entry door labeled, "Fitness and Therapy Center." Once inside the facility the surveyor was told by therapy business office manager (TBOM)-L the surveyor entered through the wrong set of doors, "but it was ok, as one led (set of doors) to the other." On March 31, 2025, at 9:45 a.m., previous licensed assisted living director (PLALD)-D stated she thought the outpatient therapy clinic was "ran" (operated) through a different entity. PLALD-D stated she had never been asked that question before and she would call to find out	0 100		

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0 100	Continued From page 3 about the therapy/fitness center. During the entrance conference on March 31, 2025, at 10:07 a.m., PLALD-D and assisted living director in residency (ALDIR)-A stated the licensee was familiar with current minimum assisted living requirements. PLALD-D stated the licensee did not employ physical or occupational therapists; however, later during the survey process PLALD-D stated the therapist were employees of the licensee. On March 31, 2025, at 10:36 a.m., the surveyor asked PLALD-D if the licensee had a variance for the Fitness and Therapy Center? PLALD-D stated she was not aware of the need for a variance. PLALD-D stated she would check with the CEO (chief executive officer). On March 31, 2025, at 11:18 a.m., during a tour of the facility with PLALD-D and ALDIR-A the surveyor observed several people swimming in a pool. On March 31, 2025, at 2:15 p.m., PLALD-D stated community members and residents both received services from the therapy staff. On March 31, 2025, at 2:42 p.m., PLALD-D stated the licensee employed the therapists who worked in the therapy/fitness center. "We (licensee) pay their (therapist's) wages so there was not any issue with the license. PLALD-D stated the licensee used (name of billing company) a billing service. PLALD-D stated therapy employees got paid through the assisted living (licensee) but when "outsiders" (non-residents) came in and used the services provided then the therapist's wage was paid through a different service. PLALD-D stated	0 100		

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0 100	Continued From page 4 if/when Med A (Medicare part A/ covered inpatient hospital stays, skilled nursing facility care, hospice care, some home health care) (name of company) was used to collect payment. PLALD-C stated if/when home care was involved the licensee "backed off" the therapist's wages. During an independent tour of the facility on March 31, 2025, at 4:17 p.m., the surveyor observed inside the entry of the fitness and therapy center a small table that held a tri-fold brochure titled with the licensee's name, Schedule & Memberships: once opened the full page was labeled, Fitness Center Class Schedule, and included: - fitness center hours: 7:30 a.m. until 6:00 p.m., seven days a week - Sunday: no classes, pool closed - Monday: aqua splash, Zumba (dance-based fitness technique), aqua arthritis, chair yoga, aqua arthritis - Tuesday: PiYoChi (blend of Pilates and yoga), yoga, aqua aerobic, functionally fit, aqua fit, open swim - Wednesday: aqua splash, Zumba, aqua arthritis, chair yoga, aqua arthritis - Thursday: PiYoChi, yoga, aqua aerobic, functionally fit, aqua fit, open swim - Friday: aqua splash, Zumba, aqua arthritis, chair yoga, aqua arthritis - Saturday: no classes, pool closed. The back page included directions for installing mobile app for name of licensee. *register for classes *view your schedule - directions for downloading the app, and memberships: - tier one- $28.00 basic membership gym use only	0 100		

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0 100	Continued From page 5 - tier two- $43.00 included one class of your choice/week - tier three- $55.00 included two classes of your choice/week - tier four: $73.00 unlimited classes of your choice/week *(Silver Sneaker (health and fitness program designed for adults 65+ that is included with many Medicare Advantage plans), Silver Fit (health and wellness program, often offered by Medicare Advantage or Medigap plans) and Optum members (individuals who have access to a range of health services and benefits) pay the difference between tier one and desired tier) (tier two -four included use of gym in membership) personal training gym: $40.00 for 45 minutes session (five pack $180. ten pack $340) personal training pool: $50 for 45 minutes session (five pack $270, ten pack $500). Hours of operation: Monday-Sunday 7:30 a.m. -6:00 p.m. In addition, there was a business card rack on the small table that held six different cards: - name, contact information, and occupation/title: physical therapist (PT) - name, contact information, and occupation: PT - name, contact information, and occupation: occupational therapist, registered and licensed (OTR/L) - name, contact information, and occupation: OTR/L - name, contact information, and occupation: PT assistant (A) - name, contact information, and occupation: business manager. On April 3, 2025, at 7:52 a.m., the surveyor observed four women playing volleyball in the pool, and one staff in the pool area and PTA was	0 100		

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0 100	Continued From page 6 assisting a male in the gym area. The gym area included several machines and tables, a classroom, and exam room 1, exam room 2. On April 3, 2025, at 11:24 a.m., PLALD-D stated she was told that "we" (licensee) are serving the residents, and a separate license was not required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
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	0 480		

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0 480	Continued From page 7 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 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	0 480		

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0 480	Continued From page 8 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 1, 2025, 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		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection	0 510		

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0 510	Continued From page 9 control standards were followed by one of three employees, unlicensed personnel (ULP-G), while providing health monitoring services to one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 1, 2025, at 7:24 a.m., the surveyor observed ULP-G gather a blood glucose (BG) meter, lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood), and a BG testing strip from the medication cart. ULP-G removed a blood pressure (BP) machine from the bottom drawer of the medication cart. ULP-G applied hand sanitizer. ULP-G cleaned the BP machine. ULP-G took the BG monitoring equipment and the BP machine to R5's room. ULP-G applied gloves. ULP-G asked R5 which finger he would like "poked" (lancet used on). R5 raised the middle finger on his right hand. ULP-G opened an alcohol pad and reached for R5's hand. R5 extended the pointer finger of R5's right hand. ULP-G cleaned the finger with the alcohol pad, used the lancet, placed the drop of blood on the BG meter to obtain a reading of 114. ULP-G removed gloves. ULP-G applied the BP cuff around R5's right arm and received a BP reading of 147/77. The surveyor did not observe ULP-G perform hand hygiene after BG monitoring, glove removal, and prior to BP monitoring.	0 510		

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0 510	Continued From page 10 On April 1, 2025, at 7:35 a.m. ULP-G stated it was" not normal" to wash hands after BG monitoring, after removal of gloves and prior to BP monitoring. ULP-G stated she washed her hands prior to assisting and after assisting R5. On April 1, 2025, at 11:05 a.m., registered nurse (RN)-B stated hand hygiene should have been done after BG monitoring, as blood was involved, and prior to BP monitoring. On April 3, 2025, at 11:28 a.m., clinical nurse supervisor (CNS)-C stated hand hygiene should have occurred. The licensee's Handwashing for Employee's policy dated August 2021, noted employees would follow proper hand hygiene at all times. Failure to properly wash hands would result in corrective action and retraining. The licensee's Hand Hygiene policy dated July 2021, noted hand washing was the primary way to prevent the spread of infectious organisms causing the spread of disease to the resident/and/or health care worker. Frequency: - before beginning your shift - before and after contact with each resident - before applying and after removing gloves - before and after personal use of the toilet - after sneezing, coughing, blowing or wiping nose or moth, smoking or eating - if hands are visibly soiled (soap and water method only). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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	30986	A. BUILDING: _____ B. WING _____	04/03/2025

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0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included the completion of baseline TB screenings for two of four employees (unlicensed personnel (ULP)-H, ULP-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 660		

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0 660	Continued From page 12 situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility's TB risk assessment was completed on July 11, 2024, and was determined to be a low risk level. ULP-H ULP-H was hired on August 19, 2024, to provide direct care services to residents of the facility. On April 3, 2025, at 6:47 a.m., the surveyor observed ULP-H enter the secured unit. ULP-H stated she was the medication passer for the night shift. ULP-H stated a narcotic count would soon be done between the night ULP and the on-coming day ULP medication passer. ULP-H's employee record did not include: - a QuantiFERON-Plus (TB) blood test or a two-step Tuberculin Skin Test (TST) - a completed Baseline TB Screening for health care workers (HCW) dated within 90 days of hire. On April 3, 2025, at approximately 10:30 a.m., the surveyor reviewed ULP-H's record to include a TB file with previous licensee assisted living director (PLALD)-D. PLALD-D stated ULP-H's TB file did not contain either of the above listed items. PLALD-D stated she would reach out to human resources (HR) and to ULP-H to see if ULP-H ever handed in the TB testing/screening information. PLALD-D stated there had been a separation of employment, and about a three-month gap the licensee was without a "staffing specialist". The surveyor never received either of ULP-H's TB screenings.	0 660		

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0 660	Continued From page 13 ULP-N ULP-N was hired on August 21, 2024, to provide direct care services to residents of the facility. ULP-N's employee record included a QuantiFERON-Plus test result dated August 26, 2024. ULP-N's employee record did not include a completed Baseline TB Screening for HCW dated within 90 days of hire. On April 3, 2025, at 10:49 a.m., PLALD-D stated ULP-N's record did not include a TB screening. PLALD-D stated the staff responsible for TB testing/screening had taken the position in December 2024 (ULP-N and ULP-H were hired prior). The licensee's TB Screening (TST and blood serum testing) policy dated July 2022, noted, at the time of hire and prior to any contact with the residents, all employees (and volunteers if applicable) would be screened for TB consistent with the "TB Infection control Policy". A two-step TST or blood serum laboratory screening was required for baseline TB screening of HCWs. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated May 17, 2019, screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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0 775	Continued From page 14	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: 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 April 1, 2025, from 11:00 a.m. to 1:30 p.m., with assisted living director in residence (ALDIR)-A, previous licensed assisted living director (PLALD)-D, and director of maintenance (DM)-F, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: MARKED EXIT DOOR MAINTENANCE The exterior door marked as an exit on the north end of the secured dementia care unit was not operational and would not open when tested.	0 775		

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0 775	Continued From page 15 During the tour DM-F, stated the magnetic door lock hardware had failed in the open position and needed replacement. During the tour DM-F, also stated the parts to repair the magnetic door lock hardware were ordered and the standard door locking hardware installed on the door was modified so the door could not be opened to exit without special knowledge. During the tour DM-F, ALDIR-A, and PLALD-D, stated the staff in the secured dementia care unit were trained how to operate the door to exit in the event of a fire or similar emergency or use a secondary provided exit door. EXIT DOOR HARDWARE OPERATION During the tour it was observed the exit doors leading into the corridor from the tenant parking garages were provided with a lock that required a key to operate the lock in order to exit the parking garages in the event of a fire or similar emergency in the garage. It was also observed the only doors provided to the exterior were overhead doors used for vehicle access which required special knowledge in order to open to exit in the event of a fire or similar emergency. It was explained that all spaces within the building are required to be provided with access to an exit with hardware that is readily openable from the inside without the use of keys, tools or special knowledge. EXTERIOR EXIT GATE LOCKING	0 775		

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0 775	Continued From page 16 The exterior exit gates that are part of the required marked exit path leading to the public way (parking lot/ street) from the dementia care building were locked with a chain and padlock requiring a key to unlock from the interior. It was explained to DM-F, that the exterior exit gates are required to be openable to exit from the egress side with exit hardware that will open without the use of keys, tools, or special knowledge the same as the exit doors leading out of the building. EXIT DOOR SPECIAL LOCKING ARRANGEMENTS There was a controlled egress locking system installed on all exit doors leading to the exterior exit path from the dementia care unit. The controlled egress door locking system was not provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of an emergency. It was explained the controlled egress locking system is required to be provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of an emergency. During an interview at 10:15 a.m., ALDIR-A, and PLALD-D, stated the procedures required to operate and unlock the controlled egress door	0 775		

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0 775	Continued From page 17 locking system were not included in the fire safety and evacuation plan. It was explained that the procedures required to operate and unlock the controlled egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE RESISTANT RATED DOORS The fire-resistant rated doors were held open with kick down door devices designed to hold the doors open and not connected to release to close with activation of the fire alarm system leading in the tenant parking garages. It was explained to ALDIR-A, PLALD-D, and DM-F, that fire-resistant rated doors are required to automatically close, and latch as designed and installed at the time of construction. FIRE RESISTANT RATED WALLS There was a hole in the fire-resistant rated wall inside the elevator equipment room near resident sleeping unit 151. It was explained to ALDIR-A, PLALD-D, and DM-F, that fire-resistant rated walls are required to be maintained with no holes through the drywall membrane and the drywall membrane is required to be securely fastened in place. STORAGE IN EXIT PATH There was storage of moving carts and furniture	0 775		

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0 775	Continued From page 18 in the exit path leading from the multipurpose room to the exit stairway on second floor. It was explained to DM-F, ALDIR-A, and PLALD-D, that the marked exit paths are required to be maintained clear of obstructions that prevent immediate and full use of the exit path in the event of a fire or similar emergency. ELECTRICAL EXTENSION CORDS There was electrical extension cords routed around the door opening on the wall and used as a permanent power source for equipment in the office near resident sleeping unit 248 and in the training room near the elevator on second floor. It was explained electrical extension cords shall be used for temporary power only and not routed around or through the building structural elements according to the cord manufactures user manual and MSFC in Minnesota Rules Chapter 7511. During the facility tour ALDIR-A, PLALD-D, and DM-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=D	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	0 780		

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0 780	Continued From page 19 bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On a facility tour on April 1, 2025, from 11:00 a.m. to 1:30 p.m., with assisted living director in	0 780		

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0 780	Continued From page 20 residence (ALDIR)-A, previous licensed assisted living director (PLALD)-D, and director of maintenance (DM)-F, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms in resident sleeping units 122 and 132. During the tour the smoke alarms were tested by DM-F, and it was observed the smoke alarms installed in resident sleeping units 122 and 132 were not interconnected so activation of one alarm activates all alarms throughout the sleeping unit. All sleeping units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the sleeping unit. During the tour the smoke alarms were tested and ALDIR-A, PLALD-D, and DM-F, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Two (2) day.	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	0 810		

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0 810	Continued From page 21 (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: Based on observation, interview and record review, the licensee failed to provide required training for residents. 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).	0 810		

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0 810	Continued From page 22 The findings include: On April 1, 2025, at 10:00 a.m., assisted living director in residence (ALDIR)-A, and previous licensed assisted living director (PLALD)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required training was provided to residents annually. During an interview on April 1, 2025, at 10:05 a.m., ALDIR-A, and PLALD-D, stated the required FSEP training was provided to residents upon admission but not documented as provided to the residents annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial	01540		

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01540	Continued From page 23 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care employees received the required amount of dementia care training in the required time frame for one of three employees, clinical nurse supervisor (CNS-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee had a current assisted living facility with dementia care license. CNS-C was hired on December 9, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On March 31, 2025, at 10:08 a.m., during the	01540		

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01540	Continued From page 24 entrance conference, assisted living director in residency (ALDIR)-A, previous assisted living director (PLALD)-D, and registered nurse (RN)-B stated CNS-C was the CNS for the facility. ALDIR-A stated CNS-C worked Monday through Friday from 8:00 a.m. until 4:30 p.m. On April 3, 2025, at 7:55 a.m., ALDIR-A and PLALD-D stated CNS-C had worked over 80 hours at the facility. CNS-C's record included: - dementia, activities: dated December 12, 2024, 0.75 hour (45 minutes) - dementia activities, leisure and life enriching activities: dated December 12, 2024, 0.75 hour - dementia communication, family support: dated December 12, 2024, 0.5 hour (30 minutes) - dementia communication, overview: dated December 12, 2024, 1.0 hour (60 minutes) - dementia communication, reality and validation: dated December 12, 2024, 0.75 hour - dementia overview, overview: dated December 12, 2024, 1 hour - dementia, Person-centered care: dated December 12, 2204, 0.75 hour - dementia problem solving, overview: dated December 13, 2024, 0.75 hour - dementia communication: dated April 2, 2025, 1.0 hour. CNS-C record contained 6.25 hours of dementia training completed on December 12, 2024, and December 13, 2024; and another one hour of dementia training completed on April 2, 2025. CNS-C's employee record did not contain documentation CNS-C completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of	01540		

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01540	Continued From page 25 CNS-C's hire date. On April 3, 2025, at 9:28 a.m., CNS-C's employee record was reviewed with PLALD-D. PLALD-D stated CNS-C had completed all the training that had been assigned to CNS-C. PLALD-D stated she would look into why CNS-C had not been assigned the correct number of dementia training hours. PLALD-D stated she would contact corporate, as CNS-C's training needs were "preloaded" per role assigned/hired for. PLALD-D asked if CNS-C was considered direct care staff? PLALD-D confirmed CNS-C did not have the required dementia hours as required. On April 3, 2025, at 10:02 a.m., PLALD-D stated CNS-C missed a BELTSS (board of executives for long-term services and supports) dementia class that totaled three hours. The licensee's Dementia Care Training policy dated July 2021, noted supervisors of direct care staff must have at least eight (8) hours of initial training on dementia within 120 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01560 SS=D	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:	01560		

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01560	Continued From page 26 (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (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 ensure dementia training included all the required content for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee had a current assisted living facility with dementia care license. CNS-C was hired on December 9, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees.	01560		

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01560	Continued From page 27 On March 31, 2025, at 10:08 a.m., assisted living director in residency (ALDIR)-A and previous assisted living director (PLALD)-D, and registered nurse (RN)-B stated CNS-C was the CNS for the facility. CNS-C's record included: - dementia, activities: dated December 12, 2024 - dementia, activities, leisure and life enriching activities: dated December 12, 2024 - dementia communication, family support: dated December 12, 2024 - dementia communication, overview: dated December 12, 2024 - dementia communication, reality and validation: dated December 12, 2024 - dementia overview, overview: dated December 12, 2024 - dementia, Person-centered care: dated December 12, 2204 - dementia, problem solving, overview: dated December 13, 2024 - dementia communication: dated April 2, 2025. CNS-C's record did not include: - dementia: assistance with activities of daily living. On April 3, 2025, at 10:16 a.m., PLALD-D stated she would look into the training CNS-C's completed to see if dementia: assistance with activities of daily living was completed. The surveyor asked PLALD-D to inform the surveyor by noon the following day, if CNS-C had completed the required training. PLALD-D did not contact the surveyor. ALDIR-A did inquire via email on April 3, 2025, at 3:38 p.m., if correction orders 1540 and 1560 could be combined as both orders were related to specific training for the same staff member (CNS-C).	01560		

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01560	Continued From page 28 The licensee's Dementia Care Training policy dated July 2021, noted only staff that have received dementia specific training shall be assigned to care for dementia residents. The training would consist of topics recommended by the Alzheimer's Association with a core focus of Person-Centered quality care. The initial training would include the following minimum areas of topic: a. an explanation a Alzheimer's disease and other dementia's b. assistance with activities of daily living c. problem solving with challenging behaviors d. communication skills e. person-centered planning and service delivery. understanding cognitive impairment, and behavioral and psychological symptoms of dementia, g. standards of dementia care, including nonpharmacological dementia care practices that are person-centered, and evidence informed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01640 SS=E	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	01640		

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01640	Continued From page 29 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 service plans were revised to include provided services for three of five residents (R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3's diagnoses included dementia, adjustment disorder with anxiety, memory loss, and diabetes. R3's service plan dated March 5, 2025, included	01640		

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01640	Continued From page 30 medication administration twice daily. R3's medication administration record (MAR) dated March 1, 2025, through March 31, 2025, included medication administration at: 6:50 a.m., 8:20 a.m., 11:40 a.m., 4:40 p.m., 9:00 p.m. R3's master assessment dated March 20, 2025, include: - staff to administer all medications per MD (medical doctor) orders. On April 1, 2025, at 11:30 a.m., the surveyor observed licensed practical nurse (LPN)-I inject 0.25 milligrams (mg) of Ozempic (diabetes/weight loss) into R3's right abdomen site using correct technique. R3's service plan was not revised as required, to include medication administration five times daily. On April 3, 2025, at 10:19 a.m., R3's service plan and MAR were reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R3's service plan did not indicate R3 received medication administration five times daily. CNS-C stated, "oh yeah", R3 got insulin administration which was not included on R3's service plan. R4 R4's diagnosis included Alzheimer's dementia, history of falls, and diabetes. R4's service plan dated March 24, 2025, indicated R4 received the following services: - behavior: verbal aggression, three times daily (each shift) - medication administration five times daily - blood glucose checks five times daily.	01640		

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01640	Continued From page 31 R4's service recap summary dated March 1, 2025, through March 31, 2025, included: - active March 25, 2025, safety checks scheduled every 30 minutes around the clock. On March 31, 2025, at 1:58 p.m., the surveyor observed unlicensed personnel (ULP)-G tell R4 she could administer R4's insulin in either R4's arm or belly. ULP-G injected six units of Lyumjev (short acting/diabetes) insulin into R4's right arm using correct technique. R4's service plan was not revised as required, to include safety checks. On April 1, 2025, at 3:53 p.m., registered nurse (RN)-B reviewed R4's service plan with the surveyor. RN-B stated safety checked were added on March 25, 2025, after an incident. RN-B stated there was an unsigned service plan awaiting a signature for R4. The surveyor requested to review R4's unsigned service plan. On April 2, 2025, at 12:36 p.m., R4's unsigned service plan was reviewed by the surveyor. The date on R4's unsigned service plan was April 2, 2025, (today's date). R5 R5's diagnosis included neurocognitive disorder, major depressive disorder, diabetes, and atherosclerotic heart disease (ASHD/buildup of fats, cholesterol and other substances in and on the artery walls.) R5's service plan dated January 14, 2025, indicated R5 received the following service: - blood pressure (BP) monitoring by LPN fourth Tuesday, check and record BP, notify RN if: systolic (top number) BP is less than 90 or	01640		

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01640	Continued From page 32 greater than 180 and the diastolic (bottom number) is less than 50 or greater than 90. R5's vital signs dated March 2, 2025, through April 2, 2025, included: BP monitoring daily: - BP was monitored 32 of 32 opportunities - BP ranged from 172/85 to 113/63. R5's prescriber order dated April 2, 2024, included: - BP monthly. On April 1, 2025, at 7:24 a.m., the surveyor observed ULP-G take R5's BP with correct technique to obtain a BP of 147/77. On April 3, 2025, at 7:42 a.m., the surveyor observed ULP-O take R5's BP with correct technique to obtain a BP of 153/84. R5's service plan was not revised as required, to include daily BP monitoring. On April 2, 2025, at 12:15 p.m., R5's service plan was reviewed with CNS-C. CNS-C reviewed R5's record in the computer, service plan in the system, for current services. CNS-C stated R5's service plan in the computer system did include daily BP monitoring. CNS-C stated R5's BP monitoring had not been removed and currently that service was provided and R5's service plan did not reflect R5's daily BP monitoring. The licensee's Service Plan, Implementation and Revisions policy dated April 2022, noted the service plan must be revised, if needed, based on resident reassessment. Any revisions must include a signature or other authentication by the facility and by the resident or their responsible party documenting agreement on the services to	01640		

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01640	Continued From page 33 be provided. The facility must provide information to the resident or their responsible party about changes in the fee for services and how to contact the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for three of four residents (R4, R3, 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	01750		

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01750	Continued From page 34 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: R4 R4's diagnosis included Alzheimer's dementia, history of falls, and diabetes. R4's service plan dated March 24, 2025, indicated R4 received the following services: - medication administration five times daily - blood glucose (BG) checks five times daily. R4's medication administration record (MAR) dated March 1, 2025, through March 31, 2025, included: - Lyumjev Kwikpen (short acting insulin pen)100 units/milliliter (ml) inject 8 units subcutaneous (SQ/under skin, into fatty tissue), at breakfast - Lyumjev Kwikpen 100 units /ml, inject 5 units at lunchtime - Lyumjev Kwikpen 100 units /ml, inject 4 units at supper In addition, the MAR included a sliding scale to be given in addition to each scheduled dose with meals: - Lyumjev Kwikpen 100 units/ml, sliding scale: inject SQ for: 85-199 or below = no units 200-274= 1 units 275-349 - 2 units 350-above =3 units. Document units of sliding scale given in the notes. R4's prescriber order dated March 27, 2025,	01750		

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01750	Continued From page 35 included the above orders. On March 31, 2025, at 1:58 a.m., the surveyor observed unlicensed personnel (ULP)-G tell R4 she could administer R4's insulin in either R4's "arm or belly". ULP-G injected six units of Lyumjev insulin into R4's right arm using correct technique. On March 31, 2025, at 2:12 p.m., R4's MAR was reviewed with ULP-G. ULP-G stated R4's MAR did not instruct ULPs to rotate sites or was there a place to document site injection. ULP-G stated she had been here so long she (ULP-G) "just knew" to rotate sites. On April 1, 2025, at 11:11 a.m., the surveyor reviewed R4's MAR with registered nurse (RN)-B. RN-B looked at the MAR and stated, "they (ULPs) are not seeing it (place to document injection site)." RN-B went to another screen on R4's EMAR and found a drop-down box to where injection sites could be entered. RN-B stated there was no direction for ULPs to document injection sites or for ULPs to review insulin injection site prior to insulin administration. RN-B was not able to locate drop down boxes/instructions for insulin administration, to rotate sites in resident records. The manufacturer's instructions for Lyumjev insulin dated October 18, 2024, pick a spot to inject- belly, upper legs, upper arms, or buttocks. Choose a different spot each time you inject to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. R3	01750		

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01750	Continued From page 36 R3's diagnoses included dementia, adjustment disorder with anxiety, memory loss, and diabetes. R3's service plan dated March 5, 2025, indicated R3 received the following services: - medication administration twice daily - BG monitoring four times daily. R3's MAR dated March 1, 2025, through March 31, 2025, included: - fluticasone-salmeterol inhalation 250/50 aerosol power breath activated 500/50 micrograms (mcg); one puff inhaled orally every 12 hours for asthma - Lantus Solostar (long-acting insulin pen) 100 units/ml, inject 10 units SQ at bedtime - Ozempic (diabetes/weight loss) 0.25 or 0.5 mg/dose 2 mg/3 ml, inject 0.25 mg SQ once weekly - insulin aspart (type one diabetes/short acting insulin pen) 100 units/ml, use the following sliding scale to administer insulin SQ before each meal: 149 or less =0 units 150-199- 1 unit 200-249= 2 units 250-299= 3 units 300-349= 4 units 350-greater=5 units. R3's prescriber order dated March 12, 2025, included the above order. On April 1, 2025, at 11:30 a.m., the surveyor observed licensed practical nurse (LPN)-I remove two pens from a locked cabinet and go to R3's room. R3 showed LPN-I her BG meter (continuous/ less invasive) reading of 119. LPN-I asked R3 if she would like the injection in her stomach? LPN-I injected the correct dose of Ozempic into R3's right abdomen. LPN-I told R3,	01750		

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01750	Continued From page 37 R3 did not require sliding scale insulin this day. On April 1, 2025, at 4:01 p.m. RN-B stated "one of the RN's" did not include specific instruction in R3's record to rinse and spit after inhaler use as required per manufacturer's directions. In addition, RN-B confirmed R3's record lacked to include specific instructions to rotate injection sites per manufacture's instruction as required. The manufacturer's instructions for fluticasone-salmeterol dated January 2020, noted rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. The manufacturer's instructions for Lantus dated 2022, noted change (rotate) injection sites within the area you chose with each does to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The manufacturer's instructions for Ozempic dated September 2023, noted inject Ozempic SQ to the abdomen, thigh, or upper arm. Use a different injection site each week when injecting in the same body region. When using Ozempic with insulin, administer as separate injections and to never mix the products. It is acceptable to inject Ozempic and insulin in the same body region, but the injections should not be adjacent to each other. The manufacturer's instructions for insulin aspart dated August 15, 2023, noted you can inject your insulin Aspart in your thighs, stomach, upper arm, or buttocks Never inject insulin Aspart into a muscle. Change (rotate) the injection site within the chose area with each dose; try to avoid injecting the same site more often than once every one to two weeks.	01750		

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01750	Continued From page 38 R5 R5's diagnosis included neurocognitive disorder, major depressive disorder, diabetes, and atherosclerotic heart disease (ASHD/buildup of fats, cholesterol and other substances in and on the artery walls.) R5's service plan dated January 14, 2025, indicated R5 received medication administration five times daily. R5's MAR dated March 1, 2025, through March 31, 2025, included: - tamsulosin (enlarged prostate, difficulty urinating) 0.4 mg daily, give one capsule by mouth daily, 5:00 p.m. - Lantus 100 units/ml, inject 20 units SQ every night. Hold for blood glucose less than 100. R5's prescriber order dated April 2, 2024, included the above orders. On April 1, 2025, at 7:24 a.m., the surveyor observed ULP-G monitor R5's BG obtain a BG reading of 114. ULP-G told R5 she (ULP-G) would be "right back" with R5's medication. On April 1, 2025, at 11:11 a.m., RN-B was not able to locate drop down boxes/instructions for insulin administration, to rotate sites in any of the licensee's resident records. On April 2, 2025, at 12:28 p.m., clinical nurse supervisor (CNS)-C stated she was not familiar with the manufacturer's directions for tamsulosin. CNS-C looked at her phone and stated, "oh, I see what you are talking about" (directions at Drugs.com for tamsulosin). CNS-C stated R5 normally ate dinner "around" 4:30 p.m. daily, so she	01750		

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01750	Continued From page 39 "thought" the manufacturer's directions were being followed for tamsulosin. CNS-C confirmed R5's record did not include specific instructions as required for R5 tamsulosin. The manufacturer's instructions for tamsulosin dated January 15, 2028, noted take tamsulosin 30 minutes after the same meal each day. Follow the directions on your prescription label carefully. Take tamsulosin exactly as directed. Swallow tamsulosin capsules whole; do not spilt, chew crush or open them. The licensee's Administration of Insulin policy dated May 2024, noted specific instructions on how to administer MUST be in the EMAR (electronic) for unlicensed staff. The licensee's Medication Management Services policy dated January 2024, noted the RN would develop specific procedures for medication management services that staff would provide. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 40 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 trained medication administration process was followed by one of two employees, unlicensed personnel (ULP)-J, for two of two residents (R9, R10). Further, the licensee failed to ensure one of two ULPs (ULP-E) followed registered nurse (RN) written instructions for one of two residents (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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ADMINISTRATION PROCESS R9 R9's diagnosis included dementia, constipation, allergies, neuropathy (nerve pain/ damage), depression with anxiety, stomach ulcer, and chronic pain. R9's service plan dated January 8, 2025, indicated R9 received medication administration	01760		

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01760	Continued From page 41 twice daily. R9's medication administration record (MAR) dated March 1, 2025, through March 31, 2025, included: - gabapentin 300 milligrams (mg) take two capsules (600 mg) for pain and neuropathy, 8:10 a.m. - fluticasone (allergies) 50 micrograms (mcg) spray, instill one spray into both nostrils once daily, 8:10 a.m. - hydrocodone/acetaminophen (moderate to severe pain)10-325 mg, 8:10 a.m. - methenamine hippurate (antibiotic to treat and prevent urinary tract infections) 1 gram, 8:10 a.m. - omeprazole (stomach ulcer) 40 mg, 8:10 a.m. - oxybutynin (overactive bladder) 5 mg, 8:10 a.m. - potassium Cl 10 milliequivalents (mEq) take four tablets, 8:10 a.m. - vitamin B2 (supplement) 100 mg, take four tablets, 8:10 a.m. - cetirizine (allergies) 5 mg, 8:10 a.m. - donepezil (dementia, 5 mg, 8:10 a.m. - duloxetine (depression) 20 mg, 8:10 am. - vitamin D3 (supplement) 50 mcg, 8:10 a.m. R9's prescriber order dated March 6, 2025, included the above orders. R10 R10's diagnosis included cognitive communication deficit, weakness, hypertension (HTN/high blood pressure), dysphasia (difficulty swallowing) and heart block with pacemaker placement. R10's service plan dated May 9, 2024, indicated R10 received medication administration twice daily.	01760		

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01760	Continued From page 42 R10's MAR dated March 1, 2025, through March 31, 2025, included: - levothyroxine (thyroid) 88 mcg, 8:00 a.m. - simvastatin (cholesterol) 40 mg, 8:00 a.m. - vitamin D3 (supplement) 2000 units, 8:00 a.m. - acetaminophen (mild pain) 500 mg, take two tablets, 8:00 a.m. - aspirin (heart health) 81 mg, 8:00 a.m. -carvedilol (heart) 6.25 mg, 8:00 a.m. - docusate sodium (bowels) 100 mg, 8:00 a.m. - duloxetine (depression) 20 mg, 8:00 a.m. - furosemide (diuretic/HTN) 20 mg, 8:00 a.m. - gabapentin 100 mg, 8:00 a.m. - hydrocodone/acetaminophen 5 mg/325 mg, 8:00 a.m. R10's prescriber order dated August 8, 2024, included the above orders. On April 1, 2025, at 8:46 a.m., the surveyor observed ULP-J review R9's MAR and add a narcotic medication to a cup of medication ULP-J had prepared. ULP-J reviewed R10's MAR and added a narcotic to a cup if medication ULP-J had prepared. ULP-J took the medication cups of medication and fluticasone inhaler to R9's room and administered R9's medication. ULP-J took a prepared medication cup to R10's room and administered R10's morning medication. ULP-J stated she did not identify the medication cups for R9 and R10. ULP-J stated she knew whose medications were who's as one medication cup had more medication than the other medication cup. On April 1, 2025, at 11:10 a.m., RN-B stated the facility did not have a good system for medication administration for the residents. RN-B stated the licensee needed to come up with a better process, as the ULPs were trained to gather	01760		

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01760	Continued From page 43 more than one resident's medication at one time. RN-B stated she would prefer the medication cups used were labeled for each resident and the narcotics were gathered first and then the medication cups were added to. On April 3, 2025, at 11:39 a.m., clinical nurse supervisor (CNS)-C stated she would prefer two medication cups be used that were correctly labeled and that staff gathered the narcotic first. CNS-C stated the ULPs were trained to collect the medications at the same time. FOLLOWING WRITTEN INSTRUCTION R7 R7's diagnosis included dementia, memory loss, and asthma. R7's service plan dated January 9, 2025, indicated R7 received medication administration twice daily. R7's MAR dated March 1, 2025, through March 31, 2025, included: - fluticasone HFA 220 mcg inhaler (reduces inflammation). Inhale one puff by mouth twice a day-use with spacer, rinse mouth with water and spit after use. R7's prescriber order dated April 10, 2024, included the above order. On April 1, 2025, at 9:02 a.m., the surveyor observed ULP-E ask R7 to step out of the dining room area for medication administration. R7 agreed and walked out of the dining room. ULP-E held a fluticasone inhaler and a spacer out to R7. R7 stated she did not need (want to use) the spacer. R7 stated it was just a "puffer." R7 inhaled the fluticasone inhaler. The surveyor did	01760		

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01760	Continued From page 44 not observe ULP-E offer or suggest to R7 to rinse mouth after use. Directly after the above observation ULP-E R7's MAR was reviewed with ULP-E. ULP-E stated she did not ask, offer, or suggest to R7 to rinse her mouth out after inhaler administration. ULP-E stated she "usually" had R7 rinse her mouth out after use. R7 On April 1, 2025, at 11:04 a.m., RN-B stated directions on the MAR were to be followed. The licensee's Medication Management Services policy dated January 2024, noted medication administration means performing a set of tasks that include the following: - checking the resident's medications record - preparing the medication as necessary - administering the medication to the resident - documenting the administration or reason for not administering the medication - reporting to a registered nurse or appropriate licensed health professional any concerns about the medications, the resident, or the resident's refusal to take the medication. The licensee's Medication Management Services policy dated January 2024, noted the registered nurse (RN) or clinical nurse supervisor had developed and would update as needed, and review no less than annually, specific procedures for the following: - verifying that prescription drugs were administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for two of three medication storage areas (assisted living (AL), secured unit (SU). In addition, the licensee failed to monitor for expired medication for one of five unidentified residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 31, 2025, at 11:00 a.m., the surveyor and registered nurse (RN)-B reviewed the contents of the medication storage areas. RN-B observed and confirmed the following:	01890		

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01890	Continued From page 46 AL TIME SENSITIVE INFORMATION -opened Incruse Ellipta 62.5 micrograms (mcg) inhaler (chronic obstructive pulmonary disease (COPD/a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) lacked an open or expiration date for R2. COMPLETE MEDICATION INFORMATION -opened ibuprofen 200 milligrams (mg) lacked pharmacy label, to include the original prescription to include resident's name. EXPIRED MEDICATION -opened ibuprofen 200 mg, expiration date November 2023. On March 31, 2025, at 11:05 a.m., RN-B stated there was no name or date on the ibuprofen 200 mg. RN-B stated the ibuprofen was not house stock. RN-B stated the ibuprofen should have been and would be removed from the medication cart. SU TIME SENSITIVE INFORMATION - opened Advair Diskus 250 mcg inhaler (COPD) lacked an open or expiration date for R3, with 38 doses left. The manufacturer's instructions for Incruse inhaler dated February 2022, noted safety throw away Incruse in the trash six weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler. The manufacturer's instructions for Advair Diskus dated June 2023, noted Advair Diskus should be	01890		

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01890	Continued From page 47 stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard Advair Diskus one month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes first. The licensee's Storage and Handling of Medications policy dated May 2024, noted unit the medication is 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, resident's name, prescriber's name, date pf issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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01950	Continued From page 48 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 three of three residents (R5, R6, R3) receiving the treatment of blood glucose (BG) monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 31, 2025, at 10:20 a.m., RN-B stated the licensee used "both" types of BG monitoring (continuous/ less invasive [measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm) and fingerstick monitoring). R5	01950		

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01950	Continued From page 49 R5's diagnosis included neurocognitive disorder (general term that describes decreased mental function due to a medical disease other than a psychiatric illness), major depressive disorder, diabetes, and atherosclerotic heart disease (ASHD/buildup of fats, cholesterol and other substances in and on the artery walls). R5's service plan dated January 14, 2025, indicated R5 received BG monitoring four times daily. R5's medication administration record (MAR) dated March 1, 2025, through March 31, 2025, included: -insulin aspart (short acting insulin) 100 units/milliliter (ml), inject SQ (subcutaneously/under skin into fatty tissue) 0-250 (BG) = no units 251-300= 2 units 301-350= 4 units 351-400= 6 units 401-450= 8 units 451 and above =10 units. R5's service recap summary dated March 1, 2025, through March 31, 2025, included: -record BG. R5's treatment plan dated April 1, 2025, included: - active March 27, 2024: care specialist (unlicensed personnel/ULP)-wearing gloves and following agency procedure, check BG and record. Notify RN if: BG is less than 70 or greater than 300. R5's prescriber order dated April 2, 2024, included the above order. On April 1, 2025, at 7:24 a.m., the surveyor	01950		

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MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

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01950	Continued From page 50 observed ULP-G remove a BG meter, BG testing strip, lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood) and gloves and go to R5's room. ULP-G asked R5 which finger R5 would like to have tested. R5 put out the pointer finger of R5's right hand. ULP-G cleaned R5's finger with an alcohol pad and used a lancet. ULP-G placed the blood onto the BG testing strip to obtain a BG reading of 114. On April 1, 2025, at 7:37 a.m., the surveyor reviewed R5's record with ULP-G. ULP-G stated R5's record did not indicate which type of BG monitoring system was used. ULP-G stated in the past the secured unit used both types of BG monitoring systems but not at this time. ULP-G stated only the finger poke type of BG monitoring was currently used on the secured unit. R6 R6's diagnosis included diabetes, and dementia. R6's service plan dated January 1, 2025, indicated R6 received BG monitoring daily. R6's service record: BG, active date July 27, 2023, noted: - wearing gloves and following agency procedure, check blood glucose and record. Notify RN if: BG is less than 70 or greater than 300. R6's prescriber's order dated September 26, 2024, included the above order. On April 1, 2025, at 7:55 a.m., the surveyor observed ULP-G asked R6 which finger can "I pick"? R6 held out the middle finger on her right hand. ULP-G cleaned R6's finger with an alcohol pad, used a lancet to collect a droplet of blood. ULP-G placed the blood on a BG testing strip that	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 51 had been inserted into a BG meter to obtain a BG of 166. On April 1, 2025, at 7:57 a.m., ULP-G reviewed R6's record. ULP-G stated R6's record did not note which type of BG monitoring was used. R3 R3's diagnoses included dementia, adjustment disorder with anxiety, memory loss, and diabetes. R3's service plan dated March 5, 2025, indicated R3 received the following service, record BG four times daily. R3's treatment plan dated March 31, 2025, included: - active date March 7, 2025: care specialist wearing gloves and following agency procedure, check blood glucose and record. Notify RN if: BG is less than 70 or greater than 300. R3's MAR dated March 1, 2025, through March 31, 2025, included: - True Metrix glucose test strip, check blood sugar four times daily - insulin aspart 100 units/ ml use the following scale: 149 or less =0 units 150-199=1 units 200-249= 2 units 250-299=3 units 300-349=4 units 350 or greater= 5 units - Ozempic (diabetes/weight loss) 0.25 or 0.5 milligram (mg) 2 mg/3 ml strength, inject 0.25 mg SQ once weekly. R3's prescriber order dated March 12, 2025, included the above order.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 52 On April 1, 2025, at 11:30 a.m., the surveyor observed licensed practical nurse (LPN)-I remove two pens from a locked cabinet and go to R3's room. R3 showed LPN-I her BG meter (continuous/ less invasive) reading of 119. LPN-I injected the correct dose of Ozempic into R3's right abdomen. LPN-I told R3, R3 did not require sliding scale insulin this day. LPN-I stated R3's record did not include which type of BG meter was used for R3. On April 1, 2025, at 11:19 a.m., the surveyor reviewed R6's record with RN-B. RN-B stated R6's record did not include which type of BG testing was used for R6, in secured unit. RN-B looked at over records for resident's who resided in the assisted living area who had BG monitoring. RN-B stated resident records in the assisted living portion of the facility did not include specific instructions as which type of BG monitoring system was used either. RN-B stated it may state what type of BG system was used in a resident's care plan, but RN-B stated she would not check care plan to find out and confirmed resident MARs should include the type of BG system used. The licensee's Providing and Documenting Treatment and Therapy Services policy dated June 2024, noted when a treatment or therapy was delegated or assigned to unlicensed personnel, the RN (registered nurse) or authorized licensed health professional must: -communicate with the unlicensed personnel about the individual needs of the resident. Develop written specific instructions on the treatment and therapy management plan (RTasks) for each resident and document those instructions in the resident's record.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for one of three residents (R6) observed during blood	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 54 glucose (BG) monitoring. 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: R6's diagnosis included diabetes, R6's service plan dated January 1, 2025, indicated R6 received BG monitoring daily. R6's service record: BG, active date July 27, 2023, noted: - wearing gloves and following agency procedure, check blood glucose and record. Notify RN (registered nurse) if: BG is less than 70 or greater than 300. On April 1, 2025, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-G administer oral medication to R6 who was seated in the dining/common's area. The surveyor observed two other residents seated at the dining room table with R6, one resident was eating breakfast. In addition, there were eight other residents in the dining/common's area. ULP-G asked R6 which finger can "I pick"? The surveyor did not observe ULP-G ask or offer R6 to relocate or if it was alright to check R6's BG at the dining room table. R6 held out the middle finger on her right hand. ULP-G cleaned R6's finger with an alcohol pad, used a lancet (small needle used to	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES SENIOR LIVING	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 55 poke the skin [usually on a finger] to get a small drop of blood). ULP-G placed the blood on a BG testing strip that had been inserted into a BG meter to obtain a BG of 166. On April 1, 2025, at 7:57 a.m., ULP-G stated she was not sure if it was in R6's care plan to take R6's BG at the dining room table/common's area. ULP-G stated R6 would not go back to her room. ULP-G stated she "tries" to turn her (R6) away from others (residents). ULP-G confirmed she did not ask or encourage R6 to leave the area prior to having her BG monitored. ULP-G stated she could have asked R6, but she (ULP-G) did not. On April 1, 2025, at 11:03 a.m., registered nurse (RN)-B stated ULPs were trained to ask the resident and others at the table when cares are provided at the dining room table for permission. RN-B stated R6 could be "a difficult one" (resident). RN-B stated R6's care plan did not indicate BG monitoring could be done at the dining room table. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. In addition, residents have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *04/03/25*
Time: 10:23:18
Report: 7939251068

Food and Beverage Establishment Inspection Report

Location:
Majestic Pines
1614 Golf Course Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0037520
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189997776
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 previously issued on 04/01/25 have NOT been corrected.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FRYER AND FLAT TOP AREA IN POOR CONDITION AND ENCRUSTED WITH FOOD DEBRIS

Issued on: 04/01/25 *Comply By: 04/04/25*

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

HOOD ENCRUSTED WITH DEBRIS

Issued on: 04/01/25 *Comply By: 04/08/25*

No NEW orders were issued during this inspection.

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

FOLLOW UP INSPECTION
WARE WASH MACHINE IS REACHING PROPER TEMPERATURE

Type: Full
Date: *04/03/25*
Time: 10:23:18
Report: 7939251068
Majestic Pines

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251068 of 04/03/25.

Certified Food Protection Manager: DENNIS REIF

Certification Number: FM25463 Expires: 06/17/25

Signed: NR

TANNER
COOK

Signed:

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

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

Type: Full
Date: *04/01/25*
Time: 10:52:22
Report: 7939251066

Food and Beverage Establishment Inspection Report

Location:
Majestic Pines
1614 Golf Course Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0037520
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189997776
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.

CARTONS OF SHELLED EGGS WERE BEING STORED OPEN ABOVE TOMATOES IN UPRIGHT FRIDGE

Comply By: 04/01/25

4-700 Sanitizing Equipment and Utensils

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

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

WARE WASH MACHINE NOT REACHING PROPER TEMPERATURE

Comply By: 04/01/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

UPON ARRIVAL SANITIZER RAG BUCKETS WERE BELOW THE 200PPM REQUIRED MINIMUM QUATERNARY AMMONIA CONCENTRATION

Comply By: 04/01/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

WARE WASH MACHINE NOT REACHING PROPER TEMPERATE TO SANITIZE. <160F AND PLATE TEMPERATURE NOT REACHING 160F

Comply By: 04/01/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FRYER AND FLAT TOP AREA IN POOR CONDITION AND ENCRUSTED WITH FOOD DEBRIS

Comply By: 04/04/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

HOOD ENCRUSTED WITH DEBRIS

Comply By: 04/08/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

MOP STORED HEAD DOWN IN MOP SINK

Comply By: 04/01/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = <200PPM at Degrees Fahrenheit
Location: RAG BUCKETS
Violation Issued: Yes

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

Hot Water: = at <160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: PORK
Temperature: 156 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: VEG BEEF SOUP
Temperature: 174 Degrees Fahrenheit - Location: HOT HOLD
Violation Issued: No

Process/Item: HAM
Temperature: 38 Degrees Fahrenheit - Location: UNDER FLAT TOP FRIDGE
Violation Issued: No

Process/Item: EGGS
Temperature: 39 Degrees Fahrenheit - Location: UPRIGHT FRIDGE
Violation Issued: No

Process/Item: TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP TOP - TOP
Violation Issued: No

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: PREP TOP - BOTTOM
Violation Issued: No

Process/Item: MASHED POTATO
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN
Violation Issued: No

Process/Item: SALSA
Temperature: 41 Degrees Fahrenheit - Location: COUNTER PREP TOP
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	5

DISCUSSION
DISH MACHINE MONITORING AND OPERATION

RAG BUCKETS ISSUES

GENERAL CLEANING

Type: Full
Date: *04/01/25*
Time: 10:52:22
Report: 7939251066
Majestic Pines

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251066 of 04/01/25.

Certified Food Protection Manager:_____

Certification Number: FM25463 Expires: 06/17/25

Signed:_____
DENNIS REIF
MANAGER/CFPM

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