



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 5, 2025

Licensee

The Emeralds at Grand Rapids Assisted Living LLC
2815 Highway 169 South
Grand Rapids, MN 55744

RE: Project Number(s) SL30227016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 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.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT GRAND RAPIDS A			STREET ADDRESS, CITY, STATE, ZIP CODE 2815 HIGHWAY 169 SOUTH 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: SL30227016 On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 39 residents: 33 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 650	Continued From page 2 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: CNS-C CNS-C was hired on September 14, 2021, to work at the attached long term care facility. CNS-C was hired on November 6, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Licensed practical nurse (LPN)-B stated CNS-C "helped out" at the assisted living, as needed, prior to becoming the CNS for the facility. On January 27, 2025, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-A identified CNS-C as the CNS for the facility. CNS-C's record included: - infection control: dated January 1, 2022, January 3, 2023, April 8, 2024 - person centered care for the person with dementia: dated November 1, 2024 - resident's rights: dated April 8, 2024 - abuse, prevention in persons with dementia: dated April 24, 2024 - abuse, neglect, and exploitation, mandatory report: dated April 1, 2024 - tuberculosis: dated April 8, 2024 - licensed staff compliance plan Minnesota: dated April 1, 2024 - emergency preparedness and environmental safety: dated September 14, 2021.	0 650			

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0 650	Continued From page 3 CNS-C's employee record did not include all training to include: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - handing of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints - consumer advocacy service of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - a review of the types of assisted living services the employee will be providing and the facility's category of licensure - emergency preparedness and environmental safety. On January 28, 2025, at 1:24 p.m., the surveyor reviewed CNS-C's employee record with LALD-A. LALD-A stated CNS-C had completed all of the required assisted living orientation. LALD-A stated the licensee had changed on-line training platforms (company) used and they were not able to produce CNS-C's complete training record for assisted living. LALD-A confirmed CNS-C's record did not include all of the required training. ULP-E ULP-E was hired on November 14, 2022, to	0 650			

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0 650	Continued From page 4 provide direct care and services to the licensee's residents. On January 28, 2025, at 6:30 a.m., the surveyor observed ULP-E prepare and administer R9's morning medications. ULP-E also monitored R9's blood glucose (BG) using a Dexcom system (measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm). ULP-E stated she was trained on both BG monitoring systems (Dexcom and finger poke) by registered nurse (RN). ULP-E's employee file contained: - training and competency: blood glucose testing (finger poke) dated January 16, 2025. ULP-E's employee file did not contain: - training and competency for Dexcom BG testing. On February 3, 2025, at 8:21 a.m., LALD-A confirmed, via email communication, ULP-E's record did not include training or competency for Dexcom BG. The licensee's Personnel Files/Employee Records policy dated November 2019, noted every employee of the licensee shall have a personnel file created upon hire which shall contain: - record of orientation (including required elements). Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each	0 650			

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0 650	Continued From page 5 competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	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	0 660			

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0 660	Continued From page 6 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 one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility's TB risk assessment was completed on March 12, 2024, and was determined to be a low risk level. On January 28, 2025, at 8:50 a.m., the surveyor observed ULP-E prepare and administer R17's morning medications.	0 660			

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0 660	Continued From page 7 ULP-E had a hire date of November 14, 2022, to provide direct care services to residents of the facility. ULP-E's employee record included a QuantiFERON-Plus (TB) blood test result dated November 29, 2022. ULP-E's employee record did not include a completed Baseline TB Screening for health care workers (HCW) dated within 90 days of hire. On January 28, 2025, at 2:01 p.m., licensed assisted living director (LALD)-A stated the licensee changed from Mantoux (skin testing) to blood testing (QuantiFERON) for TB testing. LALD-A stated the TB screening questionnaire was on the Mantoux form which was no longer used for the licensee. Clinical nurse supervisor (CNS)-C added the employees may still complete TB screening when sent to the clinic for the TB blood test. LALD-A and CNS-C said the licensee did not have any documentation that employees hired after the licensee had changed the process to TB blood testing from Mantoux testing completed TB screening as required. The licensee's Tuberculosis Screening and Prevention-Employee's policy dated July 31, 2023, noted employees would be screened using an individual risk assessment and symptom evaluation upon hire. 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.	0 660			

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0 660	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
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 January 28, 2025, from 10:45 a.m. to 12:30 p.m., with 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: FIRE-RESISTANT RATED DOORS	0 775			

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0 775	Continued From page 9 The resident room doors were marked fire-resistant rated doors with spring hinges installed but the doors did not automatically close, and latch as required. Fire-resistant rated doors are required to automatically close and latch. MAINTENANCE OF MARKED EXIT DOOR EGRESS PATH The exterior exit path to the public way was not maintained clear of snow on all marked exit doors leading out the back of the building into the back yard. The evacuation floor plan map also was marked leading occupants out these doors in the event of a fire or similar emergency. The exterior egress path is required to be maintained free of snow and obstruction continuous to the public way in order for occupants to travel through the exit path in the event of a fire or similar emergency. STORAGE There was boxes and storage on the floor blocking access to the emergency escape and rescue opening in the sleeping room in dwelling unit C-105. During the facility tour 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	0 780			

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0 780	Continued From page 10 for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so activation of one alarm activates all alarms within the dwelling units. 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	0 780			

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0 780	Continued From page 11 of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on January 28, 2025, from 10:45 a.m. to 12:30 p.m., with director of maintenance (DM)-F, it was observed that smoke alarms when tested were not interconnected so activation of one alarm activates all alarms in resident sleeping rooms A-102, and C-103. All dwelling units are required to be provided with smoke alarms that are interconnected so activation of one alarm activates all alarms within the dwelling unit. During the tour DM-F, stated the smoke alarms in resident sleeping rooms A-102, and C-103, when tested were not interconnected within dwelling units A-102, and C-103, so if one alarm is activated all alarms activate throughout the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 12 (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 develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810			

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0 810	Continued From page 13 the residents). The findings include: On January 28, 2025, at 10:05 a.m., licensed assisted living director (LALD)-A, and director of maintenance (DM)-F, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated May 29, 2024, failed to include the following: The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on January 28, 2025, at 10:20 a.m., LALD-A, stated resident unique needs for evacuation were in resident file or computer system but were not provided readily available for use in the event of a fire or similar emergency. 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 residents were provided the required training.	0 810			

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0 810	Continued From page 14 During an interview on January 28, 2025, at 10:35 a.m., LALD-A, stated the residents were provided training but the documentation was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 15 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R2, R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01060			

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01060	Continued From page 16 R2 R2's diagnosis R2's diagnosis included respiratory failure. R2's service plan dated November 27, 2024, indicated R2 received the following services: medication administration, cueing, pulse monitoring, and housekeeping services. R2's Progress Notes included: - dated January 13, 2025: staff called to report resident's SATs (oxygen blood saturation) 37%. She (R2) was in the bathroom and did not have her oxygen on. She was confused and blush in color they reported. Resident is also Covid positive. Staff to call 911 to take her to ER (emergency room) for evaluation - dated January 25, 2025, resident readmitted to the ALF (assisted living facility) today around 10:00 a.m. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation - the name and contact information for the location to which the resident had been relocated and any new service provider - contact information for the OOLTC - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 27, 2025, at 11:26 a.m., licensed	01060			

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01060	Continued From page 17 practical nurse (LPN)-B stated a relocation form was not completed for R2. LPN-B stated R2 was getting better and coming home (returning to facility). LPN-B stated was not sure why R2 had been sent to the long-term care facility, instead of returning to the facility. On January 27, 2025, at 1:04 p.m., the surveyor reviewed the resident roster with LPN-B. The surveyor requested R13's OOLTC notification for an absent of greater than four days. R13 R13's diagnosis included stress disorder. R13's service plan dated November 26, 2024, indicated R13 received the following services: medication administration, bathing assist, escorts, behavior support, and housekeeping services. R13's Progress Notes included: - dated November 5, 2024: resident had a fall last evening. Resident was very anxious and in pain. She (R13) was sent in at 12:40 a.m., this morning. She said she was walking back from the bathroom and tripped and fell. She was set in and admitted with a dislocation and fractures. She is scheduled for surgery. Will continue to follow up. - dated November 26, 2024: resident readmitted to facility today at approximately 1:45 p.m. R13's record lacked a written notice that contained, at a minimum: - the reason for the relocation - the name and contact information for the location to which the resident had been relocated and any new service provider - contact information for the OOLTC - if known and applicable, the approximate date	01060			

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01060	Continued From page 18 or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 27, 2025, at 3:28 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated they were aware of the requirement to notify OOLTC. CNS-C confirmed relocation forms were not completed for R2 and R13 as required. The licensee's Emergency Relocation policy dated August 1, 2021, noted in the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: - the reason for the relocation -the name and contact information for the location to which the resident had been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if know and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently know - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. The notice required under paragraph (b) must be delivered as soon as practice to: - the resident, legal representative, and	01060			

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01060	Continued From page 19 designated representative - for resident who receive home and community-based waiver services under chapter 2565 and section 256B.49, the resident's case manager, and - the Office of Ombudsman for Long-Term Care if the resident has been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide complete written instructions in the resident record for	01420			

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01420	Continued From page 20 delegated tasks for one of one resident (R3) for colostomy care (surgical operation in which a piece of the colon (large intestine/bowel) is diverted to an artificial opening in the abdominal wall). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hypertension (HTN/high blood pressure), chronic respiratory failure (oxygen dependent), and fistula of stomach and duodenum (abnormal opening in digestive tract that causes gastric fluids to seep through the lining of stomach or intestines). R3's service plan dated November 26, 2024, indicated R3 received: - assistance with a.m., (morning) cares - bathing assist - vital sign monitoring - medication administration -oxygen assistance - wound care - housekeeping services. R3's service plan did not include the service of colostomy bag assistance. On January 29, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-G check	01420			

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01420	Continued From page 21 R3's colostomy bag and replace R3's nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen/NC). R3's medication administration record (MAR) dated January 1, 2025, through January 29, 2025, included: -colostomy bag, ULP to check colostomy to ensure in place. If loose, change colostomy bag. Remove colostomy bag and throw it away. Clean area and dry. Apply wafer with opening in center hole. Place pouch on wafer and make sure it is secure. Home care changes colostomy bag every Monday, Wednesday and Friday. Staff to check that colostomy bag is intact. If not, staff to change colostomy bag. On January 29, 2025, at 9:14 a.m., the surveyor reviewed R3's MAR with clinical nurse supervisor (CNS)-C. CNS-C confirmed R3's record did not include specific instruction for ULP, to include when and what to report to nursing regarding R3's colostomy bag, such as skin breakdown or skin irritation. Licensed practical nurse (LPN)-B stated home care was doing "it" (colostomy care) and they (home care agency) stopped "on us" (licensee) and so the service was recently added. The licensee's Initiation of Services policy dated November 2019, noted when assisted living services are provided to a client (resident) the registered nurse (RN) would include written, client-specific instructions for performing any delegated task in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420			

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01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (clinical nurse supervisor (CNS)-C), received the required amount of annual dementia care training in the required. This practice resulted in a level two violation (a violation that did not harm a resident's health or		01530		

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01530	Continued From page 23 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: CNS-C was hired on September 14, 2021, to work at the attached long term care facility. CNS-C was hired on November 6, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. Licensed practical nurse (LPN)-B stated CNS-C "helped out" at the assisted living as needed prior to becoming the CNS for the facility. On January 27, 2025, at 9:45 a.m., during the entrance conference, licensed assisted living director (LALD)-A identified CNS-C as the CNS for the facility. LALD-A stated CNS-C worked Tuesday, Wednesday, and Thursdays, 8:30 a.m., until approximately 2:30 p.m. CNS-C's employee record included: - dated November 1, 2024: Person Centered Care for Person with Dementia, 0.25 hours (15 minutes) - dated December 27, 2024, Alzheimer's Disease and Related Dementia, one hour (60 minutes) - dated April 1, 2024, Abuse Prevention in Persons with Dementia, half an hour (30 minutes). CNS-C's employee record included 1.75 hours of annual training. CNS-C's employee record did not include two hours of annual dementia training.	01530			

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01530	Continued From page 24 On January 27, 2025, at 2:15 p.m., LALD-A stated CNS-C missed a class in July that was an hour long that would have brought CNS-C up to the required two hours of dementia annual training. LALD-A confirmed CNS-C had not completed two hours of annual dementia training as required. On January 28, 2025, at 11:03 a.m., CNS-C stated she was not sure how a dementia class was missing. CNS-C stated she had completed all classes that had been assigned to her. The licensee's undated Training Requirement for Assisted Living With Dementia Care policy noted direct-care employees must have completed at least eight hours of initial training on topics specified within 160 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issue arise. In addition, supervisors of direct-care staff must have at least two hours of training on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training	01560			

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01560	Continued From page 25 requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (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 observation, interview and record review, the licensee failed to ensure staff received dementia training as required for one of two employees (unlicensed personnel (ULP)-E). 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: ULP-E was hired on November 14, 2022, to provide direct care and services to the licensee's residents (long-term care attached/assisted living facility). ULP-E's job description for assisted	01560			

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01560	Continued From page 26 living/resident services coordinator, was dated March 14, 2024. On January 28, 2025, at 8:50 a.m., the surveyor observed ULP-E prepare and administer R17's morning medications. ULP-E's employee record did not include training for: - communication skills related to dementia - assistance with activities of daily living related to dementia On January 28, 2025, at approximately 1:25 p.m., ULP-E's employee record was reviewed with licensed assisted living director (LALD)-A. LALD-A stated ULP-E did not completed all of the training required related to dementia required at the time of hire. On January 28, 2025, at 1:26 p.m., LALD-A stated "corporate" assigned required training for staff and it was possible the incorrect classes were assigned to ULP-E. The licensee's undated Training Requirement for Assisted Living with Dementia Care policy noted direct-care employees must have completed at least eight hours of initial training on topics specified within 160 hours of the employment start date. Initial this initial training was compete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issue arise. Areas of required training include: -an explanation of Alzheimer's disease and other dementia's -assistance with activities of daily living	01560			

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01560	Continued From page 27 -problem solving with challenging behaviors -communication skills -person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans	01640			

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01640	Continued From page 28 were revised to include provided services for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hypertension (HTN/high blood pressure), chronic respiratory failure (oxygen dependent), and fistula of stomach and duodenum (abnormal opening in digestive tract that causes gastric fluids to seep through the lining of stomach or intestines). R3's service plan dated November 26, 2024, indicated R3 received: -assistance with a.m., (morning) cares -bathing assist -vital sign monitoring -medication administration -oxygen assistance -wound care -housekeeping services. On January 29, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-G check R3's colostomy bag (surgical operation in which a piece of the colon (large intestine/bowel) is diverted to an artificial opening in the abdominal wall), and replace R3's nasal cannula (NC/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver	01640			

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01640	Continued From page 29 supplemental oxygen). R3's medication administration record (MAR) dated January 1, 2025, through January 29, 2025, included: -colostomy bag, ULP to check colostomy to ensure in place. If loose, change colostomy bag. Remove colostomy bag and throw it away. Clean area and dry. apply wafer with opening in center hole. Place pouch on wafer and make sure it is secure. Home care changes colostomy bag every Monday, Wednesday and Friday. Staff to check that colostomy bag is intact. If not, staff to change colostomy bag. R3's service plan did not include the service of colostomy bag assistance. On January 29, 2025, at 9:14 a.m., the surveyor reviewed R3's service plan with clinical nurse supervisor (CNS)-C. CNS-C confirmed R3's service plan was not revised to include colostomy assistance. Licensed practical nurse (LPN)-B stated home care was doing "it", (colostomy care) and they (home care agency) stopped "on us" (licensee). LPN-B said colostomy care had recently been added to the services R3 received. The licensee's Service Plan Modification policy dated November 2019, if the service plan or agreement must be modified due to a change in a prescriber's order or a change in the tenant's needs, a new service plan would be completed and include: - description of changes in service - frequency of new service or of old service if terminated - who is to perform the service - frequency of supervision - change of service	01640			

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01640	Continued From page 30 - date/signature of RN (registered nurse) making changes - date/signature of tenant or the tenants' representative each time a modification was made. The signature may be obtained by mail or fax is an agreement was reached in person or by telephone. 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 relating to the administration of medications for four of four residents (R9, R10, R11, R16). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750			

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01750	Continued From page 31 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R9 R9's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs) and chronic respiratory failure. R9's service plan dated November 26, 2024, included medication administration. R9's medication administration record (MAR) dated January 1, 2025, through January 28, 2025, included: - Symbicort 160/4.5 micrograms (mcg) twice daily two puffs, (COPD) unlicensed personnel (ULP) to assist resident with two puffs inhalation twice daily - Ozempic one milligram (mg) dose, four mg/three milliliters (ml) solution (diabetes): inject subcutaneous, one mg every Thursday. R9's prescriber order dated December 19, 2024, included the above medications. On January 28, 2025, at 6:25 a.m., the surveyor observed ULP-E prepare R9's morning medications, which included a Symbicort inhaler. ULP-E handed R9 a cup of oral medication which R9 swallowed. ULP-E prepared R9's Symbicort inhaler and handed the inhaler to R9. R9 shook the inhaler and inhaled two puffs. R9 then rinsed	01750			

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01750	Continued From page 32 her mouth with water and spit the water out into the sink. Directly after the above observation ULP-E stated the inhaler must not be very "tasty" as R9 rinsed her mouth out. R9's MAR was reviewed with ULP-E and ULP-E said there were no directions in R9's MAR to rinse mouth after Symbicort use. In addition, ULP-E said R9's MAR did not include a place for ULPs to document inject sites for Ozempic administration. R10 R10's diagnosis included diabetes, anxiety disorder, major depressive disorder, and heart failure. R10's service plan dated November 26, 2024, included medication administration. R10's MAR dated January 1, 2025, through January 28, 2025, included: - Novolog 100 units/ml (short acting insulin) ULP to inject subcutaneous, six units with breakfast, plus add the sliding scale: - Novolog 100 units/ ml, ULP to add sliding scale to mealtime insulin order 0-170 =0 171-210 =1 unit 211-250= 2 units 251-290 = 3 units 291-330 = 4 units 331-370 = 5 units 371-410 = 6 units greater than 410= 7 units. R10's prescriber order dated December 30, 2024, included the above order. On January 28, 2025, at 6:42 a.m., the surveyor	01750			

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01750	Continued From page 33 observed ULP-E review R10's MAR and prepare R10's morning medication. ULP-E removed an Amelog insulin pen (short acting) from the medication cart and took the insulin pen to R10's room. The surveyor asked ULP-E about the insulin in ULP-E's hand, if it was correct insulin? (The MAR noted Novolog, and the pen noted Amelog). ULP-E stated, R10's insurance would not pay for Novolog and Amelog was sent to the licensee as a replacement for Novolog. The surveyor and ULP-E reviewed R10's insulin entry on R10's MAR. R10's MAR did not note Amelog insulin was to be administered in place of Novolog insulin. In addition, R10's MAR did not include direction to alternate injection sites for insulin injections. R11 R11's diagnoses included: glaucoma (high eye pressure) and dry eyes. R11's service agreement dated November 27, 2024, included medication administration. R11's January 1, 2025, through January 28, 2025, MAR included: - Refresh (dry eyes) instill one drop into both eyes twice daily, wait three to five minutes between drops - latanoprost 0.005% (high eye pressure) instill one drop into both eyes at bedtime, wait three to five minutes between different drops, resident keeps eye drops in her refrigerator. R11's prescriber order dated September 12, 2024, included the above medications. R11's assessment dated November 18, 2024, noted: medicatoin storage - resident keeps medications in her apartment, eye drops kept in her refrigerator.	01750			

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01750	Continued From page 34 On January 28, 2025, at 8:58 a.m., the surveyor observed ULP-E review R11's MAR and prepare R11's morning oral medication. ULP-E took a medication cup with R11's oral medication to R11's room and administered R11's oral medication. ULP-E went to R11's refrigerator and removed a single dosage vial of Refresh eye drops and instilled one drop of Refresh eye solution into each of R11's eyes. Directly after the above observation the surveyor and ULP-E reviewed R11's MAR. R11's MAR did not include the location of R11's Refresh eye drops. ULP-E stated she knew where R11's morning eye drops were, because she (ULP-E) has worked an evening shift and there was directions in the MAR for the evening eye drops. R16 R16's diagnoses included diabetes, heart failure, morbid obesity, major depressive disorder, and COPD. R16's MAR dated January 1, 2025, through January 27, 2025, included: - Breo Ellipta inhaler (1100/25 mg) inhale one puff by mouth once daily for asthma - Ozempic eight mg/three ml, inject two mg subcutaneous every seven days R16's prescriber's order dated November 21, 2024, included the above medications. On January 28, 2025, at 8:27 a.m., the surveyor observed ULP-E prepare R16's Breo Ellipta inhaler and hand the inhaler to R16. ULP-E asked R16 if R16 had enough water to rinse his mouth. Directly after the above observation R16's MAR	01750			

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01750	Continued From page 35 was reviewed with ULP-E. ULP-E said R16's MAR did not include direction to rinse mouth after inhalation. On January 28, 2025, at 10:56 a.m., clinical nurse supervisor (CNS)-C stated it made sense that resident MARs be updated with current insulin used, available. CNS-C added we get a lot of those (the pharmacy sends over a different brand (name) of insulin to be used, as there were insurance coverage issues. On January 29, 2025, at 8:55 a.m., the surveyor reviewed resident records with CNS-C. The surveyor reviewed manufacturer's instructions with CNS-C regarding insulin administration and inhalers. CNS-C stated resident MARs did not include any instruction for the documentation of injection sites as required. Further, CNS-C said inhalers did not include specific instructions such as to rinse mouth after inhalation, per manufacturer's instruction. In addition, the location of R11's Refresh eye solution was not on the MAR to indicate the location of Refresh eye solution for R11. CNS-C and licensed practical nurse (LPN)-B stated resident records lacked specific resident instructions. The manufacturer's instructions for Symbicort dated December 2017, noted after you finish taking Symbicort, rinse your mouth with water. Spit out the water. Do not swallow it. The manufacturer's instructions for Ozempic dated September 2023, noted administer Ozempic once weekly, on the same day each week, at any time of the day, with or without meals. Inject Ozempic subcutaneous to the abdomen, thigh, or upper arm. Instruct patient to use a different injection site each week when	01750			

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01750	Continued From page 36 injecting in the same body region. When using Ozempic with insulin, instruct patients to administer as separate injections and to never mix the products. It is acceptable to inject Ozempic and insulin in the same body location, but the injections should not be adjacent to each other. The manufacturer's instructions for Novolog Flexpen dated January 2019, noted change (rotate injection sites within the area of choice for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amylocidosis (skin with lumps) at the injection sites. The manufacturer's instructions for Admelog dated November 2019, noted change (rotate injection sites within the area choose for each dose to reduce your risk of getting lipodystrophy and localized cutaneous amylocidosis at the injection sites. The manufacturer's instructions for Breo Ellipa dated October 2017, noted, rinse and swish mouth thoroughly with water and spit after use. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted following completed of the nursing assessment, including an assessment of the client's (resident's) need for medications, treatment or therapy management, the RN (registered nurse) developed individualized plans for the client in conjunction with the client and/or the client's representative. The plans would address: -identification of any specific client instructions regarding medication, treatments or therapy our	01750			

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01750	Continued From page 37 agency staff would administer -any client specific requirements relating to documentation of medications, treatment or therapy administration -procedure of staff to notify the RN when there was a problem with any medications management service. The licensee's Medication Administration by Unlicensed Personnel policy dated August 2021, noted qualified unlicensed personnel may perform assistance with medication administration if the following was satisfied: -before performing the procedures, the unlicensed personnel were instructed by a licensed nurse in proper methods to perform the procedures -specific instructions for the unlicensed personnel on performing the task were written on the assignment sheet/service schedule No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760			

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01760	Continued From page 38 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 one of two unlicensed personnel (ULP-E) administered medication per manufacturer's instruction, for one of three residents (R10). In addition, the licensee failed to ensure one of two ULP (ULP-E), followed registered nurse (RN) written instructions for one of two residents (R15). 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: MANUFACTURER'S INSTRUCTION R10 R10's diagnosis included diabetes, anxiety disorder, major depressive disorder, and heart failure. R10's service plan dated November 26, 2024, included medication administration. R10's medication administration record (MAR) dated January 1, 2025, through January 28, 2025, included:	01760			

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01760	Continued From page 39 - Novolog 100 units/milliliter (ml)(short acting insulin) ULP to inject subcutaneous six units with breakfast, plus add the sliding scale - Novolog 100 units/ml, ULP to add sliding scale to mealtime insulin order: 0-170 =0 171-210 =1 unit 211-250= 2 units 251-290 = 3 units 291-330 = 4 units 331-370 = 5 units 371-410 = 6 units greater than 410= 7 units. R10's prescriber order dated December 30, 2024, included the above order. On January 28, 2025, at 6:42 a.m., the surveyor observed ULP-E review R10's MAR and prepare R10's morning medication. ULP-E removed an Amelog 100/ml (fast acting) insulin pen from the medication cart and took the insulin pen to R10's room. ULP-E dialed the pen to two units, then to six units, then reviewed R10's MAR and moved the dial two more clicks to equal eight units. The surveyor did not see ULP-E prime the insulin pen prior to use, to ensure the insulin pen worked. On January 28, 2025, at 6:52 a.m., ULP-E stated she primed the pen how she learned to, to dial the pen to two units first and then move the dial to the amount of insulin needed. ULP-E stated she did not look to see if insulin ejected from R10's insulin pen. ULP-E added she did not know she was to look at the pen for insulin ejection. ULP-E said she had asked about priming insulin pens but "never got a clear answer" to her question. The manufacturer's instruction dated January 2019, noted:	01760			

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01760	Continued From page 40 - select a dose of two units - take off the outer needle cap (save it) - and inner needle cap (throw it away) - with the pen pointing up, tap the insulin to move the air bubbles to the top - press the button all the way in and make sure insulin comes out of the needle - repeat up to two more times with the same needle if needed - if insulin does not come out after three times, change the needle and try again - if insulin still does not come out after changing the needle, the pen may be broken. On January 28, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-C stated insulin pens should be primed prior to use to ensure the pen is working correctly. CNS-C said ULPs should look for insulin. WRITTEN INSTRUCTION R15 R15's diagnoses included gastro-esophageal reflux disease without esophagitis (GERD/condition in which stomach acid repeatedly flows back up into the esophagus, causing heartburn and other symptoms). R15's service plan dated November 26, 2024, included medication administration. R15's MAR dated January 1, 2025, through January 29, 2025, included: -antacid chew, Tums extra strength chew and swallow one tablet by mouth twice daily. R15's prescriber order dated December 19, 2024, included the above order.	01760			

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01760	Continued From page 41 On January 28, 2025, at 6:35 a.m., the surveyor observed ULP-E review R15's MAR, remove a Tums from a bottle, famotidine 20 milligrams (mg) (ulcers of stomach and intestines), and vitamin D 25 micrograms (mcg) (health supplement) from a locked medication cart and place the medications into a medication cup. ULP-E poured water into a cup, closed the MAR, locked the medication cart. ULP-E went to R15's room and knocked on the door, R15 did not answer. ULP-E took the medication cup to the dining area and asked R15 if she wanted to take her morning medications, or if R15 would prefer to wait. R15 accepted the medication cup. R15 swallowed the medication from the medication cup. Directly after the above observation ULP-E returned to the medication cart and documented R15's medication as administer. R15's MAR was reviewed with ULP-E. ULP-E stated R15 swallows her medication. ULP-E added she had instructed R15 in the past to chew the Tums however R15 swallows all the medication, "she (R15) won't chew it." ULP-E added for several weeks she would put the medication into a separate medication cup, "chewable." ULP-E added she had told nursing R15 would not chew Tums as directed on the MAR. ULP-E said the nurse was aware and had made no change to R15's Tums medication. ULP-E confirmed she did not instruct R15 to chew the Tums and direction on the MAR was not followed. On January 28, 2025, at approximately 12:20 p.m., CNS-C stated directions on MARs should be followed. ULP-E should have instructed R15 to chew the Tums. The licensee's Medication Administration by	01760			

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01760	Continued From page 42 Unlicensed Personnel policy dated August 2021, noted qualified unlicensed personnel may perform assistance with medication administration if the following was satisfied: -before performing the procedures, the unlicensed personnel were instructed by a licensed nurse in proper methods to perform the procedures -specific instructions for the unlicensed personnel on performing the task were written on the assignment sheet/service schedule -any questions or concerns regarding the administration the medications would be directed to the RN or licensed personnel on call. Procedure for medication administration by ULP: -review medication service scheduled/ MAR for any instructions for resident for administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medication was stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one of one medication refrigerator. Further,	01880			

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01880	Continued From page 43 the licensee failed to ensure a medication was stored according to manufacturer's direction for eye solution for one of four residents (R7). In addition, the licensee failed to ensure medications were secure and permitted access to only authorized personnel in one of two medication carts (Team One). Also, the licensee failed to ensure medication was securely stored and only authorized personnel had access to medication being stored by the licensee for three of eight residents (R4, R16, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION REFRIGERATOR On January 27, 2025, at 10:55 a.m., during the tour of the facility with licensed practical nurse (LPN)-B and unlicensed personnel (ULP)-E the surveyor asked what the temperature the medication refrigerator was. ULP-E stated the temperature was and should be at 35 degrees Fahrenheit (F), with an acceptable temperature range from 35 to 40 degrees F. On January 27, 2025, at 10:57 a.m., the surveyor requested to review the temperature logs for the medication refrigerator. ULP-E commented the refrigerator log was "not looking so hot." LPN-B stated the medication refrigerator's temperature was to be monitored daily. -January temperature log was blank, no	01880			

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01880	Continued From page 44 temperatures recorded -December temperature log included one entry, December 11, 2024, the temperature was 38 degrees F. LPN-B and ULP-E observed and confirmed the following content: -3 unopened Admelog 100 units/milliliter (ml) (fast acting insulin/diabetes) pens for R6 -13 unopened Basaglar 100 units/ml (long acting insulin/diabetes) pens for R6 -5 unopened Admelog 100 units/ml pens for R8 -1 unopened Lantus 100 units/ml (long acting insulin/diabetes) pens for R8 -2 unopened Lantus 100 units ml pens for R9 -11 unopened Humalog 100 units/ml (short acting insulin/diabetes) pens for R9 -2 unopened lispro 100 units/ml (short acting insulin/diabetes) pens for R9 -2 unopened Admelog 100 units/ ml for R10 -2 unopened Lantus 100 units/ ml pens for R10 -1 unopened Ozempic, (diabetes/weight loss) one milligram (mg) for R6 -4 unopened latanoprost (high eye pressure) eye solution for R11. The manufacturer's instructions for Admelog dated November 2019, noted keep new pens in the refrigerator between 36 degrees F to 46 degrees F. Do not freeze. Do not use Admelog if it had been frozen. The manufacturer's instructions for Basaglar KwikPen dated July 2021, noted store unused pens in the refrigerator at 36 degrees F to 46 degrees F. Do not freeze Basaglar. Do not use if it had been frozen. The manufacturer's instructions for Lantus dated August 2022, noted before opening store Lantus	01880			

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01880	Continued From page 45 in the refrigerator (36 degrees F to 46 degrees F). The manufacturer's instructions for Humalog KwikPen dated April 2020, noted store unused pens in the refrigerator at 36 degrees F to 46 degrees F. Do not freeze your insulin. Do not use if it had been frozen. The manufacturer' instructions for lispro dated September 17, 2024, noted store unopened lispro in the refrigerator and use until expiration date The manufacturer's instructions for Ozempic dated October 2023, noted Ozempic should stay refrigerated until the first time you use it. You should keep it in the refrigerator (between 36 F to 46 F) when it's new and unused. The manufacturer's instructions for latanoprost dated February 1, 2024, noted store in the refrigerator. Do not freeze. MEDICATION STORED/ MANUFACTURER'S DIRECTION On January 27, 2025, at 10:45 a.m., during a review of the content of the Team Two medication cart with LPN-B and ULP-D, LPN-B confirmed the following: -an unopened container of latanoprost eye solution in the medication cart for R7. Directly after the above observed LPN-B stated R7's unopened latanoprost eye solution was to be stored in the refrigerator. SECURE MEDICATION STORAGE TEAM ONE MEDICATION CART On January 28. 2025, at 5:39 a.m., the surveyor observed Team One medication cart unlocked. ULP-H stated she was sorry, and yes, the	01880			

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01880	Continued From page 46 medication cart was to be locked. ULP-H stated she had just given a medication to a resident, and she did not lock the medication cart. ULP-H added she had seen the surveyor at the entrance door and had forgot to lock the cart when she went to the door. On January 28, 2025, at 5:56 a.m., ULP-H stated she had given an oxycodone (moderate to serve pain medication) to R2, and she did not lock the medication cart after she removed R2's medication as required. On January 28, 2025, at 10:41 a.m., clinical nurse supervisor (CNS)-C stated the medication carts should be locked when not "actively" in use. R4 R4's diagnosis included chronic kidney diseases, and dry eyes. R4's service plan dated November 26, 2024, included medication administration. R4's medication administration record (MAR) dated January 1, 2025, through January 27, 2025, included: Systane 0.4- 0.3 % solution (eye lubricant) instill one drop in both eyes, twice daily. R4's prescriber order dated November 22, 2024, included the above medication order. On January 28, 2025, at 7:11 a.m., the surveyor observed ULP-G review R4's MAR and remove a container of Refresh eye solution from the locked medication cart positioned in the open common's area, near the front entry and open dining area. ULP-G set the eye solution on a wheeled cart positioned near the medication cart that had a basket that contained a blood pressure machine.	01880			

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01880	Continued From page 47 ULP-G wheeled the cart to R4's room. ULP-G administered the eye solution and monitored R4's blood pressure. ULP-G returned wheeled cart to its previous location near the medication cart. ULP-G did not return R4's eye solution to the locked medication cart. ULP-G documented R4's eye solution and blood pressure results in the MAR. ULP-G walked over to an area used for a coffee bar/ half kitchen area and ULP-G's back was to the medication cart/wheeled cart. The surveyor observed five residents eating breakfast. The surveyor asked ULP-G if she was going to return the eye solution to the locked medication cart. ULP-G stated, yes, she should have and will return R4's eye solution to the locked medication cart. On January 28, 2025, at 10:42 a.m., CNS-C stated medications should be returned to medication cart and staff should not "step away" from unsecured medication. R16 R16's diagnosis included congested heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs) and psoriasis (skin condition, causing scales and rash.) R16's service plan dated November 26, 2024, indicated R16 received medication administration. On January 28, 2025, at 8:27 a.m., the surveyor observed ULP-E administer R16's morning medication. The surveyor observed a container of ketoconazole shampoo (psoriasis) positioned counter, near the kitchen sink in R16's room. R16's assessment dated October 29, 2024, noted:	01880			

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01880	Continued From page 48 -resident's medications were stored centrally within building in locked medication cart. R16's MAR dated January 1, 2025, though January 27, 2025, included: -ketoconazole shampoo%, use to shampoo scalp, leave on for five minutes, then rinse off with showers or twice weekly. R16's prescriber's order dated November 21, 2024, included the above medication order. On January 28, 2025, at 11:02 a.m., CNS-C reviewed R16's medication assessment and stated R16's assessment did not state that R16's prescribed shampoo could be left in R16's room. CNS-C said R16's ketoconazole shampoo should have been stored in the locked medication cart. R10 R10's diagnosis included: diabetes, anxiety disorder, major depressive disorder, and heart failure. R10's service plan dated November 26, 2024, included medication administration. On January 28, 2025, at 6:52 a.m., the surveyor observed ULP-E administer R10's morning medication and insulin injection. The surveyor observed three bottles of supplements in R10's room, two cranberry supplements, and one vitamin C opened container, positioned on a counter in R10's room. One of the cranberry supplement containers had been opened. Directly after the above observation ULP-E stated R10 had gone to see her urologist (urinary disorders) and the urologist had suggested cranberry supplement for R10. ULP-E added	01880			

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01880	Continued From page 49 neither were the correct ones and she (ULP-E) was assisting R10 find less expensive supplements. On January 28, 2025, at 10:55 a.m., the surveyor asked CNS-C if R10's medication assessment noted cranberry dietary supplement could be kept unsecured in R10's room. CNS-C stated she would have to review R10's medication assessment. On January 28, 2025, at approximately 12:30 p.m., LPN-B stated the cranberry and vitamin C supplements were from "yesterday" (purchased). CNS-C confirmed all of R10's medications were to be secured. The licensee's Storage of Medication policy dated December 2019, noted medications shall be stored consistent with each individual home care tenant's medication management plan and service plan. Medications managed by the home care provider shall be stored to prevent diversion of medications by tenants, or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Medications managed outside of a tenant's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01890	Continued From page 50	01890			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for two of two medication carts (Team One, Team Two). Further, the licensee failed to ensure insulin pens were maintained bearing the original prescription label with legible information including the expiration date. In addition, the licensee failed to ensure medication was correctly labeled for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The finding include: TIME SENSITIVE MEDICATION TEAM ONE MEDICATION CART On January 27, 2025, at 10:22 a.m., Team One medication cart was reviewed with licensed	01890			

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01890	Continued From page 51 practical nurse (LPN)-B and unlicensed personnel (ULP)-D. LPN-B observed and confirmed the following: - opened fluticasone propionate/salmeterol (Advair) 500/50 micrograms (mcg) (chronic inflammatory lung disease that causes obstructed airflow from the lungs/COPD) inhaler for R2, not dated - opened Incruse 62.5 milligrams (mg) inhaler (COPD) for R7, not dated - opened Arnutiy Ellipa 100 mcg inhaler (help prevent and control asthma) for R5 with 41 doses left dated December 30, 2024, (did not include an expiration date) - opened Basaglar 100 units/ milliliters (ml) (long acting insulin) pen dated January 10, for R6 LEGIBLE INFORMATION -opened Admelog 100 units/ml (fast acting insulin/diabetes) pen for R6 dated but not legible, black marker had smeared. PRESCRIPTION LABEL - a bag labeled Systane eye solution (dry eyes) for R4 contained an opened ciprodex 0.301 % eye solution (antibiotic/infection). Directly after the above observation LPN-B stated the date written on R6's Admelog insulin pen "kind of looked like a 25 and ???" LPN-B added, 25 was the only thing she (LPN-B) got certain. LPN-B confirmed the date on the Admelog pen was "hard to read", and the label was not legible. Regarding R4's eye solutions, LPN-B said, how did that happen? (R4's ciprodex eye solution stored in a bag labeled Systane eye solution). LPN-B said, I am just going to take that- (eye drop solution). LPN-B removed R4's eye solution from the medication cart. Further, LPN-B stated she knew that insulin were time sensitive and	01890			

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01890	Continued From page 52 required to be dated. The surveyor and LPN-B reviewed the manufacturer's instructions for Amutiey Ellipa. LPN-B commented that R5's inhaler required an open and expiration date. LPN-B confirmed R2, R7, R5's inhalers had not been dated as required TIME SENSITIVE MEDICATION TEAM TWO MEDICATION CART On January 27, 2025, at 10:44 a.m., the medication cart was reviewed with ULP-E and LPN-B. LPN-B observed and confirmed the following: -opened lantoprost (high eye pressure) eye solution dated January 15, (no year, noted), no expiration date -opened Incruse Ellipa inhaler for R7 dated January 22, 2025, no expiration date -open Lantus (long acting) insulin pen for R8 dated January 20, (no year noted), no expiration date -opened Admelog Solostar insulin pen dated January 21, (no year noted), no expiration date Directly after the above observation LPN-B stated it was important that time sensitive medications included both dates; open and expiration. LPN-B confirmed the licensee had a widespread issue in regards to medications. The manufacturer's instructions for Advair dated January 2019, , noted take Advair Diskus out of the foil pouch just before you use it for the first time. Write the date you opened the foil pouch in the first blank line on the label. Writer the "use by" date in the second blank line on the label. That date is one month after the date you wrote in the first line. The manufacturer's instructions for Incruse	01890			

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01890	Continued From page 53 inhaler dated February 2022, noted store Incruse in the unopened tray, and only open when ready for use. Safely 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 Arnutiy Ellipta inhaler dated August 18, 2024, noted only open the foil pouch when you are ready to use the inhaler. Throw away any open Arnuity Ellipta inhaler six weeks after opening the foil pouch or when the dose counter reaches zero, whichever comes first. The manufacturer's instructions for Basaglar KwikPen dated July 2021, noted throw away the pen you are suing after 28 days, even if it still had insulin left in it. The manufacturer's instructions Admelog dated November 2019, noted use pen for for up to 28 days after its first use. Throw away the Admelog SoloStar pen you are using after 28 days, even if it still has insulin left in it. The manufacturer's instructions lantoprost dated February 1, 2024, noted you can keep the opened bottle in the refrigerator or at room temperature for up to six weeks. The manufacturer's instructions Lantus dated August 2022, noted after 28 days throw your opened Lantus pen away-even if it still had insulin in it. The licensee's Storage of Medication policy dated December 2019, noted medication shall be stored consistent with manufacturer's	01890			

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01890	Continued From page 54 recommendations (refrigerated, room temperature, or frozen.) No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for three of three residents (R9, R10, R3) receiving treatments.	01950			

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01950	Continued From page 55 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 January 27, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B stated the licensee used "both" types of BG monitoring (continuous/ less invasive and fingerstick monitoring). BLOOD GLUCOSE MONITORING R9 R9's diagnoses included diabetes, chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs) and chronic respiratory failure. R9's service plan dated November 26, 2024, indicated R9 received the following services: - glucometer check, ULP (unlicensed personnel) to check residents blood sugar and document. Update nurse if blood sugar was greater than 400 or less than 70. - a.m. (morning), 11:00 a.m., 4:30 p.m., HS (hour of sleep). R9's medication administration record (MAR) dated January 1, 2025, through January 28, 2025, included:	01950			

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01950	Continued From page 56 - blood sugar checks, ULP to check resident's blood sugar before meals. Update nurse if blood sugars less 70 or greater than 400. R9's prescriber order dated December 19, 2024, included the above BG monitoring. On January 28, 2025, at 6:25 a.m., the surveyor observed ULP-E prepare R9's morning medications. ULP-E took R9's medication to R9's room. Once in the room ULP-E pushed a button on a Dexcom (continuous /less invasive) BG monitor positioned on R9's counter for a BG reading of 152. The surveyor observed a black case near the Dexcom monitor that contained a fingerstick BG monitoring system. Directly after the above observation ULP-E stated there had been an issue with R9's Dexcom BG machine and R9 had recently had three BG monitor sensor changes. ULP-E said that was why there was a finger poke BG machine in R9's room, if the Dexcom did not monitor R9's BG. The surveyor reviewed R9's MAR with ULP-E. R9's record did not state what type of BG monitor was used for R9. In addition, R9's MAR did not instruct ULPs to alert nursing if there were issues with the Dexcom or that a finger poke BG could be taken. R10 R10's diagnosis included: diabetes, anxiety disorder, major depressive disorder, and heart failure. R10's service plan dated November 26, 2024, indicated R10 received the following services: - glucometer check, ULP to check residents blood sugar and document. Update nurse if blood sugar was greater than 400 or less than 70.	01950			

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01950	Continued From page 57 - 8:00 a.m., 11:00 a.m., 4:00 p.m., HS R10's MAR dated January 1, 2025, through January 28, 2025, included: - blood sugar checks: ULP to document blood sugars four times a day. Call nurse if blood sugar greater than 400 or less than 70 - Dexcom GS Sensor (continuous glucose sensor) RN (resident assistant (ULP) to change sensor as needed. PRN) R10's prescriber order dated December 30, 2024, included the above BG monitoring. On January 28, 2025, at 6:42 a.m., the surveyor observed ULP-E review R10's MAR. ULP-E went to R10's room to monitor R10's BG. R10's Dexcom indicated R10's BG was at 218. ULP-E returned to the medication cart to prepare R10's insulin administration and sliding scale insulin based off R10's BG. R10's MAR entry for BG monitoring was reviewed with the surveyor, ULP-E stated R10's MAR did not indicate which type of BG monitoring system was used for R10. On January 28, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-C stated she was aware resident records did not include specific instructions needed, such as what type of blood glucose monitoring system was used. CNS-C added they (licensee) was trying to "catch those." OXYGEN R3 R3's diagnoses included hypertension (HTN/high blood pressure), chronic respiratory failure (oxygen dependent), and fistula of stomach and duodenum (abnormal opening in digestive tract that causes gastric fluids to seep through the lining of stomach or intestines).	01950			

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01950	Continued From page 58 R3's service plan dated November 26, 2024, indicated R3 received the following services: - oxygen assistance, ULP to change nasal cannula (NC/nasal cannula/a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) weekly - oxygen supplies, tubing, ULP to change green tubing every monthly on the 11th - oxygen assistance, ULP to check that concentrator is set at 2 liters per minute (LPM), ULP to check that oxygen tank is set at 2 LPN if she (R3) attends meals and activities. Check if tank is low. Change oxygen tanks before meals and activities and close tank when she (R3) gets home. R3's MAR dated January 1, 2025, through January 28, 2025, included: - oxygen at 2 LPM, oxygen to be used continuous per NC at 2 LPN with concentrator in apartment and tank when mobile in her electric wheelchair. R3's prescriber order dated December 17, 2024, included the above order. On January 29, 2025, at 8:41 a.m., the surveyor observed ULP-G check R3's colostomy bag and replace R3's NC which was attached to an oxygen concentrator. On January 29, 2025, at 8:48 a.m., R3's MAR was reviewed with CNS-C. CNS-C stated R3's record did not include instructions for ULPs to report regarding oxygen use, such as to report any breathing issues to nursing. CNS-C confirmed R3's record did not include specific instruction as required.	01950			

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01950	Continued From page 59 The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, noted following completed of the nursing assessment, including an assessment of the client's (resident's) need for medications, treatment or therapy management, the RN (registered nurse) developed individualized plans for the client in conjunction with the client and/or the client's representative. The plans would address: - Identification of any specific client instructions regarding medication, treatments or therapy our agency staff would administer - any client specific requirements relating to documentation of medications, treatment or therapy administration - procedure of staff to notify the RN when there was a problem with any medications management service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320			

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02320	Continued From page 60 Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards by one of two unlicensed personnel (ULP-E) during medication administration for R17. 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 January 28, 2025, at 8:50 a.m., the surveyor observed ULP-E prepare R17's morning medications, which included: - amlodipine besylate, 2.5 milligrams (mg), (HTN/high blood pressure) - aspirin 81 mg, (heart health) - atorvastatin calcium 40 mg (high cholesterol) - famotidine 10 mg (acid reflux) - furosemide 20 mg, take three to equal 60 mg (fluid retention/heart) - levothyroxine sodium 75 micrograms (mcg), (thyroid) take on an empty stomach at least 30 minutes prior to eating - loratadine 10 mg, (allergic), take on an empty stomach - losartan potassium 25 mg (HTN) - metoprolol succinate ER 100 mg, (heart disease) do not crush. ULP-E said R17 took her medication with pudding. ULP-E stated there were no instructions	02320			

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02320	Continued From page 61 in R17's record to use pudding as she had received a text message on her personal cell phone from licensed practical nurse (LPN)-B to give R17's medication with pudding. The surveyor observed a sign posted on R17's door which noted, "please watch (name) take her pills, due to her (R17) choking, thank you." On January 28, 2025, at 9:00 a.m., the surveyor observed ULP-E administer R17's medications mixed in pudding. ULP-E asked R17, have I wrecked chocolate pudding for you? R17 stated yes. On January 28, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-C stated R17's MAR did not note medication were to be given with pudding, pudding should not have been used during medication administration. LPN-B stated R17 was having difficulty swallowing medications. LPN-B stated the licensee got smaller medication for R17. LPN-B stated R17's daughter put that sign on the door adding the facility had nothing to do with it. On January 28, 2025, at 9:33 a.m., LPN-B stated she did not text staff instructions to give R17's medication with pudding. CNS-C said ULP-E went "rouge." The licensee's Medication Administration by Unlicensed Personnel policy dated November 2019, noted no unlicensed personnel may administer medications or assist with self-administration of medications for assisted living residents until they had taken and had successfully passed competency testing under the direction of the registered nurse (RN), and the RN delegated the task in compliance with the Minnesota Nurse Practice Act and assisted living	02320			

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02320	Continued From page 62 regulations. Procedure for medication administration: -review medication service schedule/MAR for any instructions for resident for administration. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure resident's	02430			

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02430	Continued From page 63 personal health and medical information was kept private. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 27, 2025, at 9:57 a.m., licensed assisted living director (LALD)-A and licensed practical nurse (LPN)-B stated two medication carts were in use at the facility, Team One and Team Two medication carts. TEAM ONE On January 27, 2025, at 2:00 p.m., the surveyor observed two unidentified unlicensed personal (ULP) perform a narcotic count (compare resident names, to narcotics prescribed, to counts of narcotics stored/ controlled at the facility) for the Team One medication cart. On January 27, 2025, at 2:45 p.m., the surveyor observed a narcotic ledger positioned on the top of the Team One unattended medication cart positioned near the entry of the facility, in a common's area, adjacent to the resident's main dining area. On January 27, 2025, at 2:50 p.m., LPN-B stated the narcotic ledger should be locked up and not available to others. LPN-B added the Team One	02430			

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02430	Continued From page 64 medication narcotic box was very full. LPN-B removed the narcotic ledger from the top of the medication cart and put the narcotic box in the locked medication cart. TEAM TWO On January 28, 2025, at 6:42 a.m., the surveyor observed ULP-E prepare and administer R10's morning medication. The surveyor observed two narcotic ledgers on the Team Two medication cart. On January 28, 2025, at 7:10 a.m., ULP-E stated she keeps the narcotic ledgers, "in here" motioning to the locked medication cart. ULP-E added she likes nothing on "her" medication cart. ULP-E secured the narcotic legers. ULP-E said the narcotic ledgers should be kept secured. On January 28, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-C stated she could see why narcotic ledgers should not be left out. CNS-C added it was appropriate to secure the narcotic ledger as there was resident's information in the ledgers to include resident names and medications available and when last administered. The licensee's Contents of Client (Resident) Record policy dated December 2019, noted, no personal, financial, medical, or other information about the client may be disclosed to any other person, except: - as may be required by law - to staff, another assisted living provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the resident, but only information that was necessary to provide serves - the persons authorized in writing by the resident	02430			

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02430	Continued From page 65 or resident's responsible person to receive the information, including third-party payers, or - to representatives of the commissioner authorized to survey or investigate assisted living providers. Resident records must be protected from damage, loss, and unauthorized access to resident information. The licensee's responsibilities include: - providing space for the safe and confidential storage of resident's records assuring that records were stored in a manner that would protect them from water or fire damage - establishing and implementing procedures regarding collecting and filing of documents completed by direct care staff providing services in the housing with services establishment two weeks after the end of the day service was provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			

Type: Full
Date: 01/27/25
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The Emeralds At Grand Rapids A

Food and Beverage Establishment Inspection Report

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	0	0	0

DISCUSSION

SANITIZER DISPENSER NOT ADDING ENOUGH SANITIZER TO MIXTURE, ESTABLISHMENT WILL HAND MIX

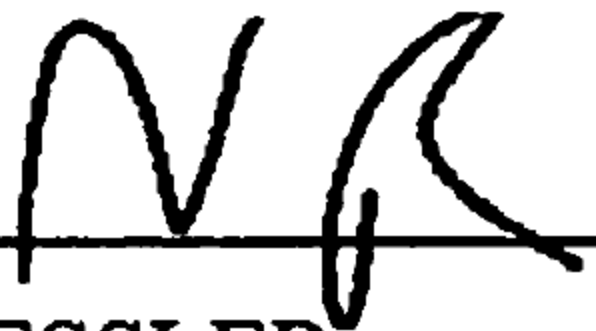
CFPM APPLICATION LEFT WITH SUSAN

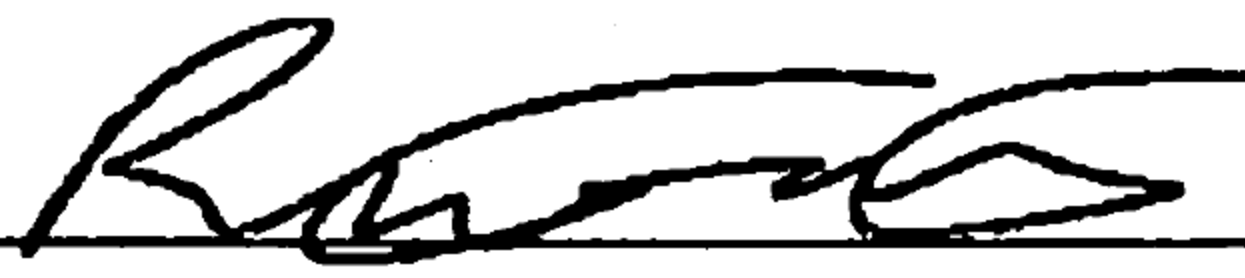
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH
inspection report number 7939251015 of 01/27/25.

Certified Food Protection Manager APPLIED

Certification Number: _____ Expires: ____/____/____

Signed: 
SUSAN KESSLER
MANAGER

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

Type: Full
Date: 01/27/25
Time: 11:51:10
Report: 7939251015

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Emeralds At Grand Rapids A
2815 Highway 169 South
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:

ID #: 0038983
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183268567
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Acid: = 0PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Acid: = 700PPM at Degrees Fahrenheit
Location: HAND MIXED SINK AND SURFACE
Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MEATBALLS
Temperature: 169 Degrees Fahrenheit - Location: STEAM TRAY
Violation Issued: No

Process/Item: TOMATO SOUP
Temperature: 41 Degrees Fahrenheit - Location: MAXIMUM FRIDGE
Violation Issued: No

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