Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 7, 2023

Licensee
Lakewood Pines
1702 Airport Road Northeast
Staples, MN 56479

RE: Project Number(s) SL30838015

Dear Licensee:

On October 24, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 23, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 23, 2023 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 23, 2023, found not corrected at the time of the October 24, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f)
1710 - Individualized Medication Monitoring And Reas - 144g.71 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on October 24, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

REQUESTING A HEARING

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

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

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

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

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	R 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30838015-1 On October 24, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 23, 2023. At the time of the survey, there were 23 active residents receiving services under the Assisted Living license. As a result of the revisit, orders 0680, 1650, and 1710 were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	{0 680}		

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{0 680}	Continued From page 2 by: Based on observation, interview, and record review, the licensee failed to prominently post an emergency disaster plan. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 24, 2023, at 9:00 a.m., the surveyor toured the main commons area and hallways and observed the facility did not have an emergency disaster plan posted prominently. On October 24, 2023, at 9:50 a.m., the surveyor requested registered nurse (RN)-I and unlicensed personnel (ULP)-E point out where the emergency disaster plan would be posted. RN-I and ULP-E were unable to locate an emergency plan. ULP-E stated, "it's not there". On October 24, 2023, at 10:05 a.m., licensed assisted living director (LALD)-A printed off a one page copy of an emergency evacuation plan to post. The surveyor provided education the evacuation plan was different than the requested facility emergency plan. LALD-A located a white binder on a shelf in the nurses office labeled [corporate name] emergency plan. On October 24, 2023, at 10:15 a.m., LALD-A	{0 680}		

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{0 680}	Continued From page 3 confirmed the emergency disaster plan was not posted. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, did not include information about posting an emergency disaster plan prominently. No further information was provided.	{0 680}		
{0 780} SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	{0 780}		

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{0 780}	Continued From page 4 This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

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{0 810}	Continued From page 5 This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	{01650}		

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{01650}	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of two residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R7's diagnoses included heart failure and hypertension. R7's service plan dated June 15, 2023, indicated R7 received services to include medication management, behavior monitoring, skin care, grooming, dressing, bathing, and emergency call pendant use. An unsigned addendum dated October 23, 2023, included toileting and transfer assist. On October 24, 2023, at 11:02 a.m., the surveyor observed unlicensed personnel (ULP)-K enter R7's room, provide transfer assist from R7's recliner to his wheelchair and oxygen transition assistance from an oxygen concentrator to a portable oxygen system via nasal cannula. ULP-K provided ambulation assistance for R7 from his room to the main dining room. R7's Task List Report dated October 24, 2023, indicated R7 had transferring and toileting assist	{01650}		

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{01650}	Continued From page 7 added to his services on October 23, 2023. R7's Service Plan dated June 15, 2023, and an unsigned addendum dated October 23, 2023, respectively, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services. On October 24, 2023, at 10:50 a.m., the surveyor requested documentation to show R7's representative had been notified of the changes to the services and had signed a new service agreement. LALD-A stated an email had been sent to the representative on October 23, 2023, for notification and acknowledgement and had not been returned. The surveyor requested a copy of the email sent to R7's representative for verification. LALD-A provided the surveyor with an email dated October 24, 2023, and time stamped 11:15 a.m. (after the surveyor requested) which had been sent to R7's representative from office administrator (OA)-G. The email included, " Nursing has done a new service agreement for dad. Could you please sign and send back as soon as possible". At 1:18 p.m., the surveyor asked OA-G if the email date and time was correct and if the email had been sent after it was requested by the surveyor. OA-G stated, "yes, I sent it today". The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must include a description of the services that are to be provided based on the most recent assessment and resident preferences, the frequency of each	{01650}		

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{01650}	Continued From page 8 service and an identification of staff or categories of personnel who would provide the service. Additionally, the policy indicated any revisions shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01650}		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment when medication related symptoms presented, and there was a change in the resident's medications for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	{01710}		

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{01710}	Continued From page 9 The findings include: R7 admitted to the facility on November 15, 2022. R7's diagnoses included heart failure and hypertension. R7's service plan dated June 15, 2023, indicated R7 received services to include medication management, behavior monitoring, skin care, grooming, dressing, bathing, and emergency call pendant use. An unsigned addendum dated October 23, 2023, included toileting and transfer assist. R7's Electronic Medication Administration Record (EMAR) dated October 2023, indicated R7 received diltiazem 180 milligrams (mg) daily for heart failure, finasteride 5 mg daily for benign prostrate, mirtazapine 15 mg daily for mood disorder, prednisone 10 mg daily for inflammation, tamsulosin 0.4 mg daily for benign prostrate, eliquis 5 mg twice daily for atrial fibrillation, metropolol 100 mg twice daily for atrial fibrillation, and voltaren gel 1% topical four times daily for pain. A progress note titled Late Entry dated October 15, 2023, written by registered nurse (RN)-I at 2:04 p.m., indicated R7 had been taken to the emergency department (ED) by family due to R7 "acting different than baseline" while out with family. R7's diagnosis was weakness and "heart rate upon arrival to the ED was 121 (standard range 60-100) which was able to be put into normal rhythm of 78. Resident came back Sunday and has orders to begin a new medication with a follow up electrocardiogram (EKG)".	{01710}		

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{01710}	Continued From page 10 A progress note dated October 16, 2023, written by RN-I at 1:42 p.m., indicated "writer received a message from [health facility name] regarding R7's new medication. Diltiazem 180 mg daily. This is to be given everyday with an EKG (records the electric signals of the heart) needed approximately three (3) days after he starts the medication. Daughter stated she can bring resident if this medication starts on October 16 or October 17. Writer had medication begin today at noon. Writer left message for the heart institute at [phone number] letting them know medication was started and to contact us if we are needing to schedule the EKG". A progress note dated October 16, 2023, written by RN-I at 1:50 p.m., indicated "writer reached out to [family member] regarding updating her as to when resident began taking the diltiazem 180 mg daily. Writer left [family member] contact information if there is anything else needed on our end regarding scheduling the EKG that is to take place approximately three (3) days after start of medication". A progress note dated October 17, 2023, written by unlicensed personnel (ULP) at 2:08 p.m., indicated "resident paged multiple times today. Wanted assistance with standing, pulling up pants, and putting oxygen back on. Resident was agitated multiple times today. Dumped afternoon medication out of cup onto plate. Needed to feed to him. Refused to keep oxygen on while in room, reminded him it is important to keep it on". A progress note dated October 20, 2023, written by ULP at 1:26 p.m., indicated " resident put on pendant once and needed assistance with toileting. He also needed assistance with toileting before and after lunch. Resident needed help	{01710}		

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{01710}	Continued From page 11 with pulling his pants up and tucking his shirts in". A progress note dated October 23, 2023, written by clinical nurse supervisor (CNS)-C at 10:13 a.m., indicated "resident is needing more assistance with toileting, he wants staff to assist with pulling pants up and down, wiping if needed, help transferring out/into chair, etc if needed. He is able to complete most on his own but benefits from staff providing direction to him and being present for support. Assessment completed and updated and service plan updated. Staff updated". R7's EMAR dated October 2023, indicated staff administered diltiazem extended release (ER) 180 mg on October 17, 18, 19, 20, 21, 22, 23, 2023, daily at 12:00 p.m. R7's progress notes dated October 16, 2023, and time stamped at 1:24 p.m., included an auto-generated drug interaction warning which alerted RN-I the new medication order for diltiazem ER 180 mg to be administered daily had a drug-to-drug interaction with several of R7's other medications. RN-I processed the order and entered the medication into R7's EMAR. The medication alert system warned of a drug-to-drug interaction between R7's diltiazem ER 180 mg, metoprolol tartrate 100 mg, tamsulosin 0.4 mg, digoxin 125 microgram (mcg) and eliquis 5 mg. R7's record included a reassessment completed on October 23, 2023, by clinical nurse supervisor (CNS)-C, however, lacked evidence of a medication review when medication related symptoms presented. On October 24, 2023, at 12:05 p.m., the surveyor interviewed RN-I and asked if RN-I was aware of	{01710}		

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	30838	A. BUILDING: _____ B. WING _____	R 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01710}	Continued From page 12 the drug-to-drug interaction alert in R7's medication record. RN-I stated she had entered the new medication order into R7's EMAR, however, was unable to locate any documentation the drug-to-drug interaction alert had been reviewed or addressed by a nurse. Additionally, RN-I stated the follow up EKG had not yet been completed after the new medication had been started. On October 24, 2023, at 12:13 p.m., RN-I phoned R7's physician to alert physician to the drug-to-drug interaction and obtained new orders to discontinue diltiazem 180 mg with blood pressure monitoring and update the physician with blood pressure readings to be taken daily. The licensee's Assessments, Reviews and Monitoring policy updated August 1, 2021, indicated the RN would reassess the resident and update the assessment including all elements of the uniform assessment tool (the uniform assessment tool includes a section for medication review). Ongoing resident reassessments and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided	{01710}		

Electronically Delivered

September 18, 2023

Licensee
Lakewood Pines
1702 Airport Road Northeast
Staples, MN 56479

RE: Project Number(s) SL30838015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30838015-0 On August 21, 2023, through August 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 41 active residents whom were receiving services under the Assisted Living license. An immediate correction order was identified on August 22, 2023, issued for SL30838015-0, tag identificaiton 1290. On August 22, 2023, the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 2 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and the licensee failed to prominently post an emergency disaster plan. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 680		

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0 680	Continued From page 3 a large portion or all of the residents). The findings include: On August 21, 2023, at 10:04 a.m., the surveyor toured the facility and observed the facility did not have an emergency disaster plan posted prominently. On August 21, 2023, at 10:17 a.m., the surveyor requested unlicensed personnel (ULP)-D point out where the emergency disaster plan would be posted. ULP-D stated, " it isn't posted, it's in the computer if we need it". On August 21, 2023, at 10:40 a.m., the surveyor observed licensed assisted living director (LALD)-A print a copy of the emergency disaster plan from a computer located in the staff office. The licensee's emergency preparedness plan dated July 2023, included emergency plans for fire, mass evacuation, severe weather, power outage, water contamination/shortage, bomb threat, flooding, gas leak, elevator emergency, and elopement/missing person. The licensee's plan lacked the following content and/or policies and procedures to address: - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records.	0 680		

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0 680	Continued From page 4 In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On August 21, 2023, at 10:35 a.m., LALD-A confirmed the emergency disaster plan was not posted and stated, "it is normally posted on the board in the hallway, we have residents that remove things". LALD-A stated the emergency plan was a plan developed in conjunction with the skilled nursing center across town and thought the current plan covered the emergency preparedness requirements. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the facility would have in place an effective and compliant emergency preparedness plan. The intent of the plan would be aligned with the Centers for Medicare and Medicaid state operations manual Appendix Z - emergency preparedness. The emergency preparedness plan would include all required elements of Appendix Z, would be in writing and reviewed annually. No further information was provided.	0 680		

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0 680	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all	0 780		

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0 780	Continued From page 6 residents and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 22, 2023, between 10:45 a.m. and 12:15 p.m., survey staff toured the facility with maintenance (M)-F. During the facility tour, survey staff observed that when the smoke alarms in resident apartment 224 were tested by M-F, the smoke alarms did not test as interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate. During the facility tour interview, M-F confirmed the findings and verified this deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 7 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with required elements; failed to provide readily available fire safety and evacuation plans; failed to provide the required employee training on fire safety and evacuation; and failed to provide training to residents capable of assisting in their own evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 8 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: On August 22, 2023, between 10:45 a.m. and 12:15 p.m., survey staff toured the facility with maintenance (M)-F. During the facility tour, survey staff observed that the location and number of resident sleeping rooms were not identified on the evacuation maps posted on the main floor. During the facility tour interview, M-F confirmed the findings and verified this deficient condition. On August 22, 2023, between 12:15 p.m. and 2:15 p.m., a record review and interviews were conducted with the licensed assisted living director (LALD)-A and M-F. 1. The fire safety and evacuation plans were not readily available. Survey staff requested the plans on August 22, 2023, at 12:15 p.m. and again at 12:45 p.m. from the LALD-A. At 1:10 p.m. the emergency plans for fire were provided for review. During interview, LALD-A verified this deficient condition. 2. Record review of the available documentation indicated that the licensee had not developed plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The plans indicated to use the RACE and PASS acronyms and included vague instructions for employees.	0 810		

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0 810	Continued From page 9 The plans were limited to instructing employees to remove tenants that are in harm's way and the fire department will rescue all other tenants and evacuate them from the building. The plans did not provide complete actions for employees to take in the event of a fire or similar emergency from the Pines location. During interview, LALD-A verified that the fire safety and evacuation plans lacked these provisions. 3. Record review of the available documentation indicated that the licensee had not developed procedures for resident movement, evacuation, or relocation during a fire or similar emergency from this facility location. The plans included vague instructions and did provide complete procedures. During interview, LALD-A verified that the fire safety and evacuation plans lacked these provisions. 4. Records were not provided to support that the employee training frequency had been met for the fire safety and evacuation plans. The LALD-A explained that the licensee had conducted fire safety and evacuation training with employees and printed off an example of a new hire training record. No additional training records were provided. The employee training frequency on the fire safety and evacuation plans of at least twice per year after hire was not met. During interview, LALD-A verified that records were not available to support that the employee training frequency had been met and verified this deficient condition. 5. Records were not provided to support that annual resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had been completed. LALD-A explained that the licensee had conducted training with residents, but this had not	0 810		

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0 810	Continued From page 10 been documented. During interview, LALD-A verified that records were not available to support that annual resident training had been completed and verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was submitted and received for one of one employee (unlicensed personnel (ULP)-E) and was affiliated with the assisted living license for two of six employees (ULP-E and maintenance (M)-F).	01290		

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01290	Continued From page 11 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on August 22, 2023 at approximately 3:05 p.m. The findings include: ULP-E ULP-E was hired on July 6, 2009, to provide direct care services to the facility's residents and continued providing care after August 1, 2021 under the assisted living license. ULP-E's record lacked documentation of a background study completed after July 6, 2009, or affiliated with the facility's assisted living license. On August 22, 2023 at 8:53 a.m., the surveyor observed ULP-E administer resident (R2)'s morning medications. M-F M-F was hired on May 21, 2018, to provide maintenance assistance for licensee's residents and continued to provide maintenance assistance after August 1, 2021, under the assisted living license. On August 22, 2023, at 10:45 a.m., the surveyor observed M-F provide a facility tour of the building to an engineer.	01290		

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01290	Continued From page 12 M-F's record lacked documentation of a background study affiliated with the facility's license. On August 22, 2023, at 12:40 p.m., licensed assisted living director (LALD)-A stated she had reviewed the background studies with the facility human resources (HR) department and verified ULP-E and M-F's background studies were not affiliated with the facility's license. LALD-A stated "I don't have what you want, he's (M-F) is not affiliated either, our HR handles the backgrounds". The licensee's Background Studies policy dated August 1, 2021, indicated licensee would use NetStudy online program and initiate a background study on all employees being considered for hire. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met and copies of completed backgrounds would be kept in individual employee records. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System	01290		

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01290	Continued From page 13 User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by review completed by evaluation supervisor on August 22, 2023, however, non-compliance remains at a scope and level of three, widespread (I).	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 14 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment by a registered nurse (RN) for one of three residents (R4) with a change of condition, including addition of interventions as needed with change of conditions. 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: R4's diagnoses included cerebral infarction (stroke). R4's Service Plan dated June 15, 2023, indicated services to include mobility reminders, medication administration, assistance with transportation and	01620		

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01620	Continued From page 15 appointments and use of an emergency call pendant. On August 23, 2023, at 1:34 p.m., the surveyor observed R4 return from an emergency room visit assisted by unlicensed personnel (ULP)-E. ULP-E assisted R4 with ambulation to his dining room table and set up lunch. R4's 90-day nursing assessment dated August 17, 2023, indicated R4 had a severe cognitive impairment, demonstrated obsessive/repetitive behaviors, was unable to follow directions, needed reminding for use of wheelchair, footwear and to wait for staff assistance if needed. R4's record indicated from June 19, 2023, through August 23, 2023, R4 had sustained 16 falls, as well as a change in ambulation ability. Progress notes indicated the following: - June 19, 2023, at 5:15 p.m., witnessed fall in main dining room, ULP reported resident got up from dining room chair and turned to walk/transfer to walker. No injuries. The fall was reported to a registered nurse on-call. The incident report was completed by a ULP, reviewed by a RN and interventions documented were discussed importance of keeping walker within reach, not attempt to ambulate without walker, not even a few steps due to impaired mobility, unsteady gait. Offer for physical therapy made and declined. - June 20, 2023, at 11:00 a.m., RN noted R4 had a witnessed fall. Tenant was getting up from dining room table, turned to grab his walker and walker was not within reach. Tenant fell when he stepped toward walker. No injury.	01620		

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01620	Continued From page 16 - June 20, 2023, at 1:52 p.m., Resident put his pendant on at 1:05 p.m. I located him in the public bathroom. He had his walker sitting outside the bathroom door. He was laying on the floor next to the toilet. He was trying to pull his pants up and lost his balance. He had bowel movement all over his pants. Nurse was notified and resident was able to stand up with a gait belt with nurses help and staff member. No change to interventions. - June 20, 2023, at 10:15 p.m., a ULP noted resident had an unwitnessed fall at 2215, arial (call pendant) was used. He denied hitting head and remembers fall. Resident transfered to hospital per nurses request. - June 21, 2023, at 8:33 a.m., RN noted two falls. Actions included reassurance, continue with current medications, be careful with transfers and using walker, follow up with physician with any further concerns. - June 22, 2023, at 8:26 a.m., clinical nurse supervisor (CNS)-C wrote: resident had an unwitnessed fall at 1:05 p.m. in the public bathroom. Resident lost his balance trying to pull his pants up. Resident had bowel movement and was trying to clean himself up. He did not have his walker with him, he left it in the hallway. CNS-C asked the reason, he reported the door makes it hard to get walker in with him. Management of the door mechanism to be discussed with housing manager. Writer educated resident on taking walker with him at all times, holding onto bars on wall and walker to get up from toilet when wiping self. Resident denies any injury or pain, did not hit his head. - June 22, 2023, at 8:33 a.m., RN wrote: resident	01620		

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01620	Continued From page 17 reports his remote for the TV fell on the floor, he got down to get it and could not get back up. Writer educated him on calling staff for assistance to get it. Resident denied injury or pain. Interventions: educated resident again on keeping walker with him at all times, slowing down, keeping walker up close to him. - June 22, 2023, at 8:40 a.m., CNS-C wrote: resident unable to report why he fell in hallway last evening. He refers to the incident two days ago when he dropped the remote and tried to pick it up. Interventions: educated resident again on keeping walker with him at all times, slowing down and keeping walker up close to him. Therapy has worked with resident in the past and resident did not do good with following instructions. - July 3, 2023, at 11:31 a.m., CNS-C wrote: writer followed up with resident today on fall. He was trying to get out main entrance with walker to go to church. He fell, did not have his emergency call pendant on him, did not call out verbally. Reports he doesn't think he was there long before staff found him. He denied pain or injury. Interventions: writer educated resident to wear call pendant at all times, encouraged to call out for help, educated resident on using automatic door openers to make it easier for him to get out. - July 4, 2023, at 2:27 a.m., ULP wrote: resident fell in his kitchen. Pushed his pendant and was pulling himself up when ULP arrived. No injuries. He had been boiling water. - July 5, 2023, at 12:47 p.m., RN wrote: writer followed up with resident on fall early Tuesday morning. He was not quite sure what he was doing up at that time, possible getting some Aleve	01620		

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01620	Continued From page 18 to help him sleep. Resident denies hitting head or injury. Resident reports he has some trouble turning around in his kitchen with walker and tray on it. Interventions: Writer reminded him to go slow, not to hurry. Tray was place on walker to assist resident with carrying things as that had caused falls previously. Writer will request therapy orders. (R4 is administered melatonin 3 milligrams (mg) and Banophen 25 mg nightly at 11:00 p.m. for sleep. R4 is independent with Aleve) - July 22, 2023, at 9:59 a.m., ULP wrote: resident was found on his bedroom floor at 8:15 a.m. lying on his stomach with his legs underneath his bed. Staff called immediately for a lift assist, then called the on-call nurse. Resident said he was trying to get into bed around midnight and fell. Residents upper stomach, below chest red on both sides and swollen. Scrape on right shoulder, elbow and right hip was red. Left elbow had a scrape, both knees were red and skin broke open. Both feet covered with scrapes and open wounds, very red. Ambulance arrived and decided resident needed to go to the hospital. Nurse was called again and notified. (R4 had received his last safety check for the night at 6:57 p.m. on July 21, 2023. A safety check was signed off as completed on July 22, 2023, at 7:51 a.m.) - July 24, 2023, at 3:16 p.m., RN processed an order and the system triggered a drug-to-drug interaction alert that was not addressed. Order as follows: Sulfamethoxazole-trimethoprim oral tablet 800-160 milligram (mg) give one (1) tablet by mouth two times a day for urinary tract infection (UTI) for 5 days. The system time stamped the following notification into the progress note: "The order you have entered has triggered the following drug protocol	01620		

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01620	Continued From page 19 alerts/warning: Drug-to-drug interaction, the system has identified a possible drug interaction with the following orders: memantine HCl oral tablet 10 mg give one tablet by mouth two times a day for cognitive decline. Severity: moderate. Interaction: mental status changes and myoclonus have been reported with the combination of sulfamethoxazole-trimethoprim oral tablet 800-160 mg and mementine HCl orat tablet 10 mg." - July 24, 2023, at 3:17 p.m., CNS-C wrote: Change in condition. Resident returned from hospital stay. Order received and processed for sulfamethoxazole-trimethoprim oral tablet 800-160 mg give one (1) tablet by mouth two times a day for 5 days to start tomorrow. Resident back to baseline, will continue in home therapies. Assessment and service plan (SP) reviewed, some additions of safety checks. Staff updated. - July 24, 2023, at 8:44 p.m., ULP wrote: tenant arial (call pendant) alerted staff he had fallen on floor of bathroom when rising up from the toilet. Tenant was helped to standing and seated on toilet with gait belt and two staff. Tenant was checked for injury, bandage reapplied to knee. Fall report made, nurse notified. Per nurse, tenant instructed to arial alert staff for gait belt assisted transfers in apartment. - July 25, 2023, at 12:24 p.m., an RN wrote: seen by [physician name], drink plenty of fluids, empty bladder regularly, placed order for two-wheel walker with no seat. Stop Aricept. - July 26, 2023, at 1:11 p.m., CNS-C wrote: 90-day, met with resident for 90-day review of services. [ULP-D's name] providing services today. Resident has remained independent with	01620		

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01620	Continued From page 20 supports of medication management and administration, cognitive support, scheduling of appointments and transportation, meals and emergency pendant. Resident noted to be wearing pendant at time of visit and demonstrated ability to use. Upon assessment today, resident reports good appetite, sleeping well at night, normal urination and bowel movements. Resident reports things have been going well and is happy with service provided and staff doing good job when assisting resident. Resident denies any questions or concerns at this time. Instructed to let staff know if any questions or concerns. Care plan (CP), service plan (SP), POLST, current medication list reviewed, no changes needed at this time, uniform assessment tool reviewed, refer to further details. - July 26, 2023, at 1:25 p.m., CNS-C wrote: writer followed up with resident after fall. He denies pain or injury. Reports some leg weakness yet from previous fall. He continues to work with therapies. Writer educated resident on using his emergency call pendant for transfers, especially if having weakness. Service Plan updated to reflect this change. Physician was updated next day at appointment. - July 28, 2023, at 6:22 a.m., ULP wrote: Resident used arial to alert writer. Writer responded and found resident lying on the floor. Resident said they fell while getting out of bed to go to the bathroom. Resident denies hitting head or injury. Writer called 911 for a lift assist. Resident was helped up by emergency medical technicians (EMT's). Nurse notified. - July 28, 2023, at 8:51 a.m., CNS-C wrote: writer followed up with resident after fall early this morning. He reports he was getting out of bed to	01620		

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01620	Continued From page 21 go to the bathroom, his foot caught his walker when he was getting up and he fell to the floor. Denied hitting head, reports he did hit his back on the bed but not bothering him at this time. He was incontinent after that. Did use emergency call pendant, writer again explained that is why it is important to wear at all times. Writer encouraged resident to use call pendant during the night when needing to get up or use bathroom or anything else and wait for staff to come and help him, he stated he would try. Denies any pain with urination but states he goes frequently and not much at a time. PCP updated, asked about seeing urologist, waiting for reply. Resident continues to work with therapies, going to try different tray for walker and they are thinking about benefit of wheelchair. - July 28, 2023, 11:30 a.m., CNS-C wrote: Resident had a fall in elevator at 1130. He had come down as he thought it was supper. He couldn't explain why he fell. He was leaning up against the wall of the elevator. He had blood on his ear and a scrape to ankle. Writer called 911 to take resident to emergency department (ED) due to hisotry of falls and hitting head. Writer explained why he needed to go and get checked out and he said "ok" to going with EMT's. - July 28, 2023, at 1:33 p.m., CNS-C wrote in incident report: Writer heard loud crash noise, went to investigate and found resident laying in elevator with his head against the wall and neck at a crooked angle. Resident said he was ok. Writer noted blood on right ear, abrasion to right ankle. This is residents second fall today. Writer called for 911 to take resident to ED for evaluation due to multiple falls and hitting head and blood noted on ear. Writer walked away when EMT's present to get medication list to send	01620		

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01620	Continued From page 22 with, when writer returned EMT's informed writer that resident stated he did not want to go. Writer indicated yes, he needed to go due to multiple falls and history of stroke. EMT's state they cannot kidnap him and asked writer if she had power of attorney (POA) to make him. Writer stated she was the nurse and needed to make sure he is safe in the building and would talk with resident. Writer talked with resident about reasons for going to ED, writer asked if he was ok going to ED with the EMT's and he stated "ok". Resident was transported to ED. - July 28, 2023, at 8:24 p.m., ULP wrote: resident returned from ED with daughter at 5:30 p.m. Resident was taken to apartment by wheelchair and transferred to recliner. Resident was told staff would be available for all transfers by wheelchair to bathroom, downstairs for meals and whatever else he needed. He agreed to push his arial alert when help was needed. Resident was delivered meal tonight. Resident had 3:30 p.m. meds at return from ED per nurse. Resident was checked on twice throughout shift and doing well. - July 29, 2023, at 7:24 p.m., CNS-C wrote: change in condition, resident returned from hospital. No new orders, use walker at all times. SP updated to reflect change of staff assisting to bring resident down to meals in wheelchair and assist in apartment with wheelchair or walker. Resident is to call staff when needing assistance and wait until they come. Resident verbalizes understanding. - July 29, 2023, at 2:40 p.m., ULP wrote: Resident refused using the wheelchair for breakfast this morning. He kept walking with his walker. - August 1, 2023, at 10:18 p.m., ULP wrote:	01620		

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	30838	A. BUILDING: _____ B. WING _____	08/23/2023

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01620	Continued From page 23 Writer was heading down hallway and noticed resident walking down to the dining area. Writer asked how resident was and he said he was going for breakfast. Writer told resident it was still nighttime and helped resident back to apartment. - August 1, 2023, at 10:55 a.m., ULP wrote: resident fell in the dining room at 7:38 a.m. He was transferring himself from the dining room chair to his wheelchair. Resident was asked a few minutes prior to falling if he wanted to go back to his room and he said no. Resident was able to get up on his own. Nurse notified. - August 4, 2023, at 5:58 a.m., CNS-C wrote: Resident did not wait for staff to assist him back into his wheelchair after finishing breakfast. He is refusing to sit in wheelchair at table instead of transferring to chair. Staff had asked him if he was ready to go back to his apartment and he said no, then decided to transfer on his own. He denied hitting head or injury. He is oriented to his baseline. He is using walker in his apartment independently and wheelchair with staff assist long distance. He was able to get up on his own. Resident has been participating in therapy, doesn't always follow their direction. Interventions: Educated on waiting for staff to assist with transfers into and out of whleelchair to ensure he doesn't get caught up in the foot pedals. Resident verbalized understanding. - August 6, 2023, at 9:18 p.m., ULP wrote: Resident was found by another resident who had been accompanying resident in the elevator. Resident had fallen in elevator. Resident was checked for injury, no injury. Nurse notified. - August 7, 2023, at 4:11 p.m., CNS-C wrote: writer followed up with resident after falling. He	01620		

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01620	Continued From page 24 denies injury or pain. Has been up and about per normal routine. Doesn't recall why he fell. He was walking to use elevator and come down to dining room. Writer educated on reasons for falling when walking long distances without staff. Writer talked about risks vs benefits of not following direction to prevent falls. Writer explained more falls increase risk of serious injury and prevent autonomy in apartment. Resident stated writer was making this up. Writer reminded resident his doctor had same talk with him. He stated he hadn't been injured. Writer counted to him all the scrapes on his legs from last falls. Writer asked him to wait for staff to come and get him for meals and to also take his walker into bathroom on shower days instead of leaving it in the hallway and walking into bathroom as a way to prevent falls and serious injury. Waiting for new wheelchair to be approved. - August 11, 2023, at 10:17 a.m., CNS-C wrote: therapist reported to writer that she has instructed resident to use only wheelchair over the weekend, not to use walker. She said he agreed. - August 17, 2023, at 8:02 a.m., CNS-C wrote: resident was in hallway ambulating with walker, had on a pair of sandals that were noted to not be tight on his feet. He reports he lost balance and fell. Maintenance heard noise, called ULP and ULP got nurse. Resident on knees holding onto railing trying to get up. Assessed for injuries, small abrasion noted on left elbow. Resident denies hitting head or injury. Writer assisted resident up and helped back to apartment. Interventions: Educated resident on how not using wheelchair and asking for staff assistance when needing something and not wearing good sturdy footwear can lead to more falls or more	01620		

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01620	Continued From page 25 detrimental long lasting injury. Staff updated to bring resident wheelchair to him if noted to have walker and remind him to use wheelchair and good sturdy footwear. SP updated to reflect this. - August 21, 2023, at 7:32 a.m., ULP wrote: acetaminophen oral tablet 500 mg give two tablet by mouth three times a day for pain. Sent to emergency room. - August 21, 2023, at 1:06 p.m., RN-B entered the following order: Bactrim DS oral tablet 800-160 mg (sulfamethoxazole-trimethoprim) give one tablet by mouth two times a day for urinary tract infection (UTI) until August 28, 2023 at 10:00. The system auto-generated the following drug-to-drug interaction warning into the progress note when the order was entered: The order you have entered has triggered the following drug protocol alerts/warning: drug-to-drug interaction - the system has identified a possible drug interaction with the following orders: memantine HCl oral tablet 10 mg give one table by mouth two times a day for cognitive decline. severity: moderate, interaction: mental status changes and myoclonus have been reported with the combination of Bactrim DS oral tablet 800/160 mg and memantine HCl oral tablet 10 mg. - August 21, 2023, at 1:15 p.m., RN-B wrote: resident returned from ED with diagnosis UTI. Given IV antibiotics in ED and returned with orders for oral antibiotics x 7 days. Resident and daughter did consent for an increase in services as he does appear weaker with the infection and to avoid falls. Did increase vital signs (VS) monitoring as well and to push fluids with interactions to promote hydration. lung sounds clear, vital signs stable for resident but blood pressure little low along with pulse, so will monitor	01620		

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01620	Continued From page 26 that. - August 22, 2023, at 7:11 a.m., CNS-C opened progress notes and triggered the following auto-generated message into R4's progress note: The order you have entered has triggered the following drug protocol alerts/warning: drug-to-drug interaction - the system has identified a possible drug interaction with the following orders: memantine HCl oral tablet 10 mg give one table by mouth two times a day for cognitive decline. severity: moderate, interaction: mental status changes and myoclonus have been reported with the combination of Bactrim DS oral tablet 800/160 mg and memantine HCl oral tablet 10 mg. - August 22, 2023, at 7:58 a.m., ULP-E wrote: Bactrim DS oral tablet 800/160 mg give one tablet by mouth two times a day for UTI until August 29, 2023 at 23:59. Already gave order updated by RN. - August 22, 2023, at 11:59 a.m., CNS-C wrote: writer followed up with resident after fall on August 21. He was trying to get his shirt on. He reports he doesn't really remember any details. Resident noted to have small laceration above right eye which is in healing process. Resident denies injury or pain from fall. Interventions: Writer reminded to use emergency call pendant if struggling to perform tasks, wait for staff to come and they will help him. Best if he sits down to put clothes on as this way he will be more steady. Addition of dressing assist added to SP. - August 22, 2023, at 1:09 p.m., CNS-C wrote a plan of care note: writer spoke with residents daughter about falls and need for increased services. She is in agreement of increase	01620		

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01620	Continued From page 27 additional services to help prevent falls. Writer suggested she and family talk about where resident would want to go if needing higher level of care and get his name on a list. Daughter states she will talk with sister as she doesn't know how resident would pay for increased services. Daughter will help remind resident of interventions put in place. - August 22, 2023, at 2:08 p.m., ULP wrote: resident pressed arial alert at 1:25 a.m. after having been observed by writer getting ready for bed at 1:00 a.m. Writer found resident face down on his bed with his legs dangling off the edge, apparently unable to reposition himself to get completely into bed. Writer helped resident bring his legs around onto the bed, then assisted resident in scooting his bottom more onto the bed and turning him onto his back. Resident reported no injury. On-call RN notified. - August 22, 2023, at 9:05 p.m., ULP wrote: resident fell in bathroom and arial alerted staff. Nurse was notified. Nurse and two ULP's assisted resident to stand with gait belt. Resident was told by nurse to call for assistance with any movement needed in residents apartment. Resident is getting one to two hour checks per nurse. - August 23, 2023, at 6:02 a.m., ULP wrote: Resident had an unwitnessed fall. EMT's called for lift assist. Nurse notified. R4's record did not identify a fall risk assessment, a change in condition assessment or a new intervention implemented after each fall. On August 23, 2023, at 1:30 p.m., CNS-C stated the fall risk assessments are auto-generated	01620		

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01620	Continued From page 28 when an incident report is completed and available for the RN to review and add progress notes. If the RN made any changes in interventions within the fall risk assessment, those changes would auto-generate out to the staff via the computerized system. CNS-C verified if new interventions were added to fall risk assessments or services, the surveyor would see the interventions changed in the assessment and/or progress notes. Additionally, CNS-C stated the expectation was an assessment would be completed within 24 hours of a change of condition. The licensee's Assessments, Reviews and Monitoring policy dated September 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated and signed by the RN who conducted the assessment and ongoing resident reassessments and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff	01650		

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01650	Continued From page 29 who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01650		

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01650	Continued From page 30 The findings include: R2's diagnoses included diabetes mellitus and hypertension. R2's service plan dated June 15, 2023, indicated R2 received services to include medication management, a weekly blood sugar check, bathing, and emergency call pendant use. On August 22, 2023, at 8:53 a.m., the surveyor observed unlicensed personnel (ULP)-E enter R2's room and provide medications. The surveyor noted R2 was wearing a nasal cannula with twists and kinks in several locations in the tubing. ULP-E stated to R2 her nasal cannula was not placed correctly and one nasal connection was not in the proper place to provide oxygen effectively. ULP-E assisted R2 with correcting the nasal cannula, placing it properly and verifying the oxygen setting on the concentrator. R2's physician orders dated July 20, 2023, indicated oxygen one (1) LPM per nasal cannula at bedtime with concentrator to "keep stats up". R2's Service Plan dated June 15, 2023, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services. On August 23, 2023, at approximately 1:30 p.m., clinical nurse supervisor (CNS)-C verified R2's service plan did not include a description of the services to be provided, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 31 assessment and resident preferences or the identification of staff or categories of staff who would provide the services. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must include a description of the services that are to be provided based on the most recent assessment and resident preferences, the frequency of each service and an identification of staff or categories of personnel who would provide the service. Additionally, the policy indicated service plans would be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment when medication related symptoms presented, and there was a change in the resident's medications for one of three residents (R4).	01710		

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01710	Continued From page 32 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: R4 admitted to the facility on December 17, 2020, under the comprehensive home care license and continued to receive services as of August 1, 2021, under the assisted living license. R4's diagnoses included cerebral infarction (stroke). R4's Service Plan, dated June 15, 2023, indicated services to include mobility reminders, medication administration, assistance with transportation and appointments and use of an emergency call pendant. R4's Electronic Medication Administration Record (EMAR) dated August 2023, indicated R4 received aspirin 81 milligrams (mg) daily for stroke prevention, atorvastatin calcium 40 mg daily for stroke prevention, Banophen 25 mg daily for sleep aide, calcium carbonate 600/10 mg daily prevent bone loss, Certavite daily for vitamin supplement, diphendydramine 25 mg daily for sleep aide, eye drops 0.5% daily for dry eyes, loratadine 10 mg daily for allergies, melatonin 3 mg daily for sleep aide, omega 3 daily for supplement, pantoprazole 40 mg daily for digestive aide, polyethylene glycol every other day for constipation, Bactrim DS 800/160 mg twice	01710		

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01710	Continued From page 33 daily for urinary tract infection, memantine HCl 10 mg twice daily for cognitive decline, psllium husk twice daily for constipation, acetaminophen 1000 mg three times daily for pain and Gabapentin 300 mg three times daily for seizures. A progress note dated August 21, 2023, at 7:32 a.m., indicated R4 had been sent to the emergency room after a fall with increased weakness. R4 returned to the facility the same day at 12:09 p.m. with a diagnosis of urinary tract infection with hematuria (bleeding) and a superficial laceration over the right eyebrow. RN-B wrote R4's blood pressure and pulse were a little low, he appeared weaker and he would be monitored. An After Visit Summary dated August 21, 2023, indicated the attending emergency room doctor had administered Rocephin 1 gram (g) IV (intravenous) and ordered sulfamethoxazole-trimethoprim (Bactrim DS) 800-160 milligram (mg) by mouth twice daily for 7 days. R4's medical record showed R4 had four (4) falls between August 21, 2023, and August 23, 2023. The fall on August 23, 2023, at 6:02 a.m., required emergency personnel to be called for a lift assist. July 2023 and August 2023 progress notes indicate staff notified the RN after each fall. Additionally, R4's record indicated R4 had 14 falls between June 7, 2023 and August 21, 2023. During the record review of the August 2023 EMAR, the surveyor noted R4 was administered two different sleep aides each night at 11:00 p.m., melatonin 3 mg one tab daily and since August 4, 2023, Banophen 25 mg one tab at 11:00 p.m. Prior to August 4, 2023, R4 was administered diphenhydramine HCl 25 mg one tab at 11:00	01710		

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01710	Continued From page 34 p.m. with the melatonin 3 mg. R4's EMAR dated August 2023, indicated staff administered Bactrim DS (an antibiotic) 800-160 mg on August 21, 2023, in the evening, August 22, 2023, in the morning and evening and August 23, 2023, in the morning. R4's progress notes dated August 21, 2023, through August 23, 2023, included an auto-generated drug interaction warning four times and was triggered each time a nurse entered a note for R4 with the first alert time stamped into the progress notes on August 21, 2023, at 1:06 p.m. The alert warned of a drug-to-drug interaction between R4's memantine HCl 10 mg and Bactrim DS 800-160 mg causing mental status changes and myoclonus (uncontrolled muscle jerking). R4's record lacked evidence of a reassessment when there was a change in the resident's condition and medications when medication related symptoms presented. On August 23, 2023, at 11:15 a.m., the surveyor interviewed clinical nurse supervisor (CNS)-C and asked if CNS-C was aware of the drug-to-drug interaction alert in R4's medication record. CNS-C stated she had not entered the order, and was unsure if RN-A saw the alert when she entered the order, however, CNS-C stated the system would automatically issue the alert. CNS-C stated the alert would time stamp into progress notes each time a note is entered until the medication interaction was addressed and if progress notes were not reviewed it would not be seen, "it just sits in a progress note each time. This system is really different to read and understand". CNS-C stated, "I notified the doctor	01710		

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01710	Continued From page 35 when it was brought to my attention". On August 23, 2023, at 11:30 a.m., CNS-C spoke with the physician while R4 was at the emergency room and R4 received new orders: Stop Bactrim. Stop Namenda (memantine) while on Ciprofloxacin (antibiotic) for 5 days. On August 23, 2023, at 1:34 p.m., the surveyor observed R4 return from an emergency room visit due to falls, assisted by unlicensed personnel (ULP)-E. ULP-E assisted R4 with ambulation to his dining room table and set up lunch. The licensee's Assessments, Reviews and Monitoring policy updated August 1, 2021, indicated the RN would reassess the resident and update the assessment including all elements of the uniform assessment tool. Ongoing resident reassessments and monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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	01880		

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01880	Continued From page 36 review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 14, 2023, at 10:51 a.m., the surveyor observed and reviewed a medication refrigerator with licensed assisted living director (LALD)-A. LALD-A confirmed the current temperature was 29 degrees Fahrenheit (F). LALD-A stated the medication refrigerator temperatures were monitored daily and recorded on a temperature log. LALD-A stated the acceptable temperature range of 36-46 degrees F was printed on the top of the log sheet. The refrigerator contained the following medications: - three (3) unopened Basaglar 100 units/ml insulin pens for R3 The surveyor requested to review the last 30 days of temperature logs for the medication refrigerator. On August 14, 2023, at 11:00 a.m., the medication refrigerator temperature logs dated July 1, 2023, through July 31, 2023, were provided and reviewed with LALD-A. The medication refrigerator temperature log had	01880		

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01880	Continued From page 37 documentation completed 25 out of 31 days; 21 of the 25 days were documented as below the acceptable range temperature of 36 degrees F and 12 of the 25 days documented showed the temperature to be below 32 degrees F. LALD-A confirmed the actual temperatures should be recorded daily and this was not consistently being done to ensure the medication refrigerators maintained an acceptable temperature. Additionally, LALD-A stated, "the thermometer may not be working". The manufacturer's instructions for Basaglar insulin pens dated September 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F and should not be frozen. The licensee's Medication Storage policy dated August 1, 2021, noted medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	01890		

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01890	Continued From page 38 by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications being managed and stored by the licensee. 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 entrance conference on August 21, 2023, at 9:15 a.m., registered nurse (RN)-B stated the facility managed and stored residents medications in locked medication carts; medication cart one on the first floor and medication cart two on the second floor. On August 21, 2023, at 10:40 a.m., the surveyor observed the medication carts with unlicensed personnel (ULP)-D and observed the following medications to be expired: - Miralax powder 17.9 gram (g) bottle expired February 19, 2022 (medication cart one); and - Clearlax powder 17.9 (g) bottle expired July 2023 (medication cart two). On August 21, 2023, at 10:45 a.m., ULP-D stated the above medications were prescribed as needed (PRN) and both medications had expired. ULP-D removed the medications from the medication cart and stated she would notify the nurse to reorder new bottles.	01890		

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01890	Continued From page 39 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 21, 2023, at approximately 9:20 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy management services to the residents in the facility. R1 R1's diagnoses included hypertension (elevated blood pressure) and diabetes mellitus without complications. R1's service plan dated June 15, 2023, indicated R1 received services to include oxygen treatment. R1's physician orders dated July 6, 2023, prescribed oxygen two (2) liters per minute (LPM) continuous.	01940		

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01940	Continued From page 41 On August 21, 2023, at 11:26 a.m., the surveyor observed unlicensed personnel (ULP)-D enter R1's room and provide medications to R1 and noted four (4) tall and two (2) small oxygen cylinders sitting in a secured container. ULP-D checked the concentrator with an attached bubbler system (adds moisture to the oxygen inhaled) and confirmed the oxygen concentrator to be set at 2 LPM. ULP-D assisted R1 in transitioning from the oxygen concentrator to a portable tall oxygen cylinder and escort R1 to breakfast pulling the oxygen cylinder behind the wheelchair. R2 R2's diagnoses included diabetes mellitus and hypertension. R2's service plan dated June 15, 2023, indicated R2 received services to include medication management, a weekly blood sugar check, bathing, and emergency call pendant use. R2's physician orders dated July 20, 2023, indicated oxygen one (1) LPM per nasal cannula at bedtime with concentrator to "keep stats up". On August 22, 2023, at 8:53 a.m., the surveyor observed ULP-E enter R2's room and provide medications. The surveyor noted R2 was wearing a nasal cannula with twists and kinks in several locations in the tubing. ULP-E stated to R2 her nasal cannula was not placed correctly and one nasal connection was not in the proper place to provide oxygen effectively. ULP-E assisted R2 with correcting the nasal cannula and placing it properly. ULP-E checked the concentrator and confirmed the oxygen concentrator was set at 2.5 LPM. The surveyor asked ULP-E to show the	01940		

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01940	Continued From page 42 surveyor where in the EMAR the provided instructions for oxygen management and what the oxygen concentrator should be set at. ULP-E showed the surveyor an area in the electronic system where ULPs would find instructions for the task, however, ULP-E was unable to find any instructions or task assigned for oxygen management. ULP-E confirmed staff assist R2 with oxygen services and she would need to get the requested information from the nurse. ULP-E and the surveyor went to the nurses office and requested information on R2's oxygen from clinical nurse supervisor (CNS)-C and provided an update on the oxygen finding. CNS-C confirmed the most recent physician order was for 1 LPM. The surveyor observed CNS-C go to R2's room and turn the concentrator from 2.5 to 1 LPM. CNS-C instructed R2 not to adjust the dials on the concentrator. At the request of the surveyor, CNS-C used an oximeter to check the oxygen level for R2 with results of 92% on 2.5 LPM. CNS-C exited the room and the surveyor asked R2 if she had made an adjustment to the concentrator and R2 responded, "no, I haven't, the staff takes care of that". R1 and R2's Treatment/Therapy Management Plan lacked the following content: - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940		

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01940	Continued From page 43 Additionally, R2's Treatment/Therapy Management Plan did lacked a statement of they type of services that would be provided. On August 23, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-C confirmed R1 and R2's record lacked a complete and accurate individualized treatment and therapy plan. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated when the licensee managed treatment or therapy services for the resident, the facility would develop and maintain a current individualized treatment and therapy management record to include a statement of the type of service, documentation of specific resident instructions, identification of the treatment to be delegated to unlicensed personnel, and any resident-specific requirements relating to documentation of the treatment received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or	01950		

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01950	Continued From page 44 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 documented resident-specific instructions for treatments for two of three residents (R1, R2) whose oxygen treatment was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 and R2's electronic treatment administration record (ETAR) lacked specific, written instructions regarding the administration of oxygen managed by facility staff.	01950		

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01950	Continued From page 45 R1 R1's diagnoses included hypertension (elevated blood pressure) and diabetes mellitus without complications. R1's service plan dated June 15, 2023, indicated R1 received services including oxygen therapy. R1's physician orders dated July 6, 2023, prescribed oxygen two (2) liters per minute (LPM) continuous. On August 21, 2023, at 11:26 a.m., the surveyor observed ULP-D enter R1's room, provide medications to R1 and noted four (4) tall and two (2) small oxygen cylinders sitting in a secured container. ULP-D checked the concentrator with an attached bubbler system (adds moisture to the oxygen inhaled) and confirmed the oxygen concentrator to be set at 2 LPM. ULP-D assisted R1 in transitioning from the oxygen concentrator to a portable tall oxygen cylinder and escort R1 to breakfast pulling the oxygen cylinder behind the wheelchair. The surveyor asked ULP-D to show the surveyor where in the ETAR it provided instructions for oxygen management and what the oxygen concentrator and cyclinders should be set at. ULP-D showed the surveyor an area in the electronic system ULP's were able to sign off "oxygen use: requires assistance". ULP-D was unable to find any specific instructions or LPM for the oxygen being administered. R2 R2's diagnoses included diabetes mellitus and hypertension. R2's service plan dated June 15, 2023, indicated R2 received services to include medication management, a weekly blood sugar check,	01950		

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01950	Continued From page 46 bathing, and emergency call pendant use. R2's physician orders dated July 20, 2023, indicated oxygen one (1) LPM per nasal cannula at bedtime with concentrator to "keep sats up". On August 22, 2023, at 8:53 a.m., the surveyor observed ULP-E enter R2's room and provide medications. The surveyor noted R2 was wearing a nasal cannula with twists and kinks in several locations in the tubing. ULP-E stated to R2 her nasal cannula was not placed correctly and one nasal connection was not in the proper place to provide oxygen effectively. ULP-E assisted R2 with correcting the nasal cannula and placing it properly. ULP-E checked the concentrator and confirmed the oxygen concentrator was set at 2.5 LPM. ULP-E returned to the medication cart to document the medications administered. The surveyor asked ULP-E to show the surveyor where in the ETAR it provided instructions for oxygen management and what the oxygen concentrator should be set at. ULP-E showed the surveyor an area in the electronic system where ULP's would find instructions for the task, however, ULP-E was unable to find any instructions or task assigned for oxygen management. ULP-E confirmed staff assist R2 with oxygen services and she would need to get the requested information from the nurse. ULP-E and the surveyor went to the nurses office and requested information on R2's oxygen from clinical nurse supervisor (CNS)-C and provided an update on the oxygen finding. CNS-C confirmed the most recent physician order was for 1 LPM. The surveyor observed CNS-C go to R2's room and turn the concentrator from 2.5 to 1 LPM. CNS-C instructed R2 not to adjust the dials on the concentrator. At the request of the surveyor, CNS-C used an oximeter to check the	01950		

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01950	Continued From page 47 oxygen level for R2 with results of 92% on 2.5 LPM. CNS-C exited the room and the surveyor asked R2 if she had made an adjustment to the concentrator and R2 responded, "no, I haven't, the staff takes care of that". On August 23, 2023, at 1:30 p.m., CNS-C confirmed there were no specific instructions for R1 or R2's oxygen management for ULPs. CNS-C stated orders would be entered into the progress notes and should push through the electronic system for staff to get updates. The surveyor asked if R2's oxygen levels had been checked since CNS-C turned the oxygen concentrator down to 1 LPM on the morning of August 21, 2023. CNS-C stated she had added the task for ULPs to check oxygen levels daily and the surveyor requested the last two days results. CNS-C stated on August 22, 2023, results were 88% and on August 23, 2023, results were 88% on 1 LPM continuous. The surveyor asked CNS-C if the oxygen saturation level should be higher and CNS-C stated, "yes". The surveyor asked if the physician should be notified at 88%, CNS-C stated, "yes". The surveyor asked if CNS-C had provided instructions for the staff checking R2's oxygen levels. CNS-C stated, parameters were added to notify the nurse if results were below 90%. The surveyor asked if staff had notified a nurse the last two days of results at 88%. CNS-C stated, "no". The licensee's Medication and Treatment Administration and Delegation policy dated August 1, 2021, indicated when administration of medications, treatments or therapies were delegated to unlicensed personnel the registered nurse (RN) would specify, in writing, specific instructions for each resident and document those instructions in the resident's record.	01950		

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01950	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee lacked proper documentation of oxygen treatment effectiveness or treatment completion for two of three residents (R1, R2) whose oxygen treatment was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01960		

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01960	Continued From page 49 found to be pervasive). The findings include: R1 R1's diagnoses included hypertension (elevated blood pressure) and diabetes mellitus without complications. R1's service plan dated June 15, 2023, included oxygen treatment twice daily and as needed (PRN). R1's physician orders dated July 6, 2023, prescribed oxygen two (2) liters per minute (LPM) continuous. On August 21, 2023, at 11:26 a.m., the surveyor observed ULP-D enter R1's room and provide medications to R1 and noted four (4) tall and two (2) small oxygen cylinders sitting in a secured container. ULP-D checked the concentrator with an attached bubbler system (adds moisture to the oxygen inhaled) and confirmed the oxygen concentrator was set at 2 liters per minute (LPM). ULP-D assisted R1 in transitioning from the oxygen concentrator to a portable tall oxygen cylinder and escort R1 to breakfast pulling the oxygen cylinder behind the wheelchair. R1 and the surveyor returned to the medication cart and the surveyor asked ULP-D to show the surveyor where in the electronic treatment administration record (ETAR) it provided instructions, parameters for oxygen management and what the oxygen concentrator and cyclinders should be set at or to document the effectiveness. ULP-D showed the surveyor an area in the electronic system ULPs were able to sign off a task labeled "oxygen use: requires assistance". ULP-D was unable to find or point out any other	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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
01960	Continued From page 50 documentation area related to oxygen treatments available to staff. R2 R2's diagnoses included diabetes mellitus and hypertension. R2's service plan dated June 15, 2023, indicated R2 received services to include medication management, a weekly blood sugar check, bathing, and emergency call pendant use. R2's physician orders dated July 20, 2023, indicated oxygen one (1) LPM per nasal cannula at bedtime with concentrator to "keep sats up". On August 22, 2023, at 8:53 a.m., the surveyor observed ULP-E enter R2's room and provide medications. The surveyor noted R2 was wearing a nasal cannula with twists and kinks in several locations in the tubing. ULP-E stated to R2 her nasal cannula was not placed correctly and one nasal connection was not in the proper place to provide oxygen effectively. ULP-E assisted R2 with correcting the nasal cannula and placing it properly. ULP-E checked the concentrator and confirmed the oxygen concentrator was set at 2.5 LPM. The surveyor and ULP-E returned to the medication cart and the surveyor asked ULP-E to show the surveyor where in the ETAR it provided instructions for oxygen management, what the oxygen concentrator should be set at and where staff would document on the treatment. ULP-E showed the surveyor an area in the electronic system where ULP's would find instructions for the task, however, ULP-E was unable to find any instructions or task assigned for oxygen management. ULP-E confirmed staff assist R2 with oxygen services and she would need to get the requested information from the nurse. ULP-E	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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
01960	Continued From page 51 and the surveyor went to the nurses office and requested information on R2's oxygen from clinical nurse supervisor (CNS)-C and provided an update on the oxygen finding. CNS-C confirmed the most recent physician order was for 1 LPM. The surveyor observed CNS-C go to R2's room and turn the concentrator from 2.5 to 1 LPM. CNS-C instructed R2 not to adjust the dials on the concentrator. At the request of the surveyor, CNS-C used an oximeter to check the oxygen level for R2 with results of 92% on 2.5 LPM. CNS-C exited the room and the surveyor asked R2 if she had made an adjustment to the concentrator and R2 responded, "no, I haven't, the staff takes care of that". On August 23, 2023, at 1:30 p.m., CNS-C confirmed there were no areas for staff to document the effectiveness or whether the treatment was completed or not for R1 or R2's oxygen management. CNS-C stated, orders would be entered into the progress notes and should push through the electronic system for staff to get updates. The surveyor asked if R2's oxygen levels had been checked since CNS-C turned the oxygen concentrator down to 1 LPM on the morning of August 21, 2023. CNS-C stated she had added the task for ULPs to check oxygen levels daily and the surveyor requested the last two days results. CNS-C stated on August 22, 2023, results were 88% and on August 23, 2023, results were 88% on 1 LPM continuous. The surveyor asked CNS-C if the oxygen saturation level should be higher and CNS-C stated, "yes". The surveyor asked if the physician should be notified at 88%, CNS-C stated, "yes". The surveyor asked if CNS-C had provided instructions for the staff checking R2's oxygen levels. CNS-C stated, parameters were added to notify the nurse if results were below	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

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01960	Continued From page 52 90%. The surveyor asked if staff had notified a nurse the last two days of results at 88%. CNS-C stated, "no". The licensee's Medication and Treatment Documentation and Refusal policy dated August 1, 2021, indicated when administration of medications, treatments or therapies were provided the licensee would create and maintain a correct and accurate record including the date, the time, the method of administration of all prescribed treatments, signature and title of the authorized person who provided the treatment or therapy and any follow up procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02340 SS=D	144G.91 Subd. 6 Participation in care and service planning Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: (1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; (2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and (3) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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
02340	Continued From page 53 review, the licensee failed to allow the resident to actively participate in the planning, modification, and evaluation of their care and denied the resident the right to be told in advance of, and take part in decisions regarding recommended changes for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes mellitus and hypertension. R2's service plan dated June 15, 2023, indicated R2 received services to include medication management, a weekly blood sugar check, bathing, and emergency call pendant use. R2's bedrail assessment dated September 1, 2020, indicated R2 had requested the bedrail use and wanted the bedrail for repositioning and sitting up. R2's record did not include information on when the siderail was removed following the initial assessment in September 2020. A bedrail assessment dated August 21, 2023, was completed at 2:30 p.m., and electronically signed by registered nurse (RN)-B (after the bedrail was observed by the surveyor and brought to the attention of the nurses). On August 21, 2023, at 11:49 a.m., the surveyor	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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
02340	Continued From page 54 observed ULP-E enter R2's room and provide medications. The surveyor noted R2's twin bed had a rectangular, white consumer bedrail attached on the left side. The bedrail measured 36 inches in height from the floor and 17 inches in length, secured with two rods that slid between the box spring and the top mattress. The consumer rail had a 5.5 inch gap between the top of the mattress and the top of the rail for the full 17 inch length. On August 21, 2023, at 1:45 p.m., the surveyor requested a bedrail assessment for R2 from licensed assisted living director (LALD)-A. On August 21, 2023, at 2:22 p.m., LALD-A stated they were unable to find a bedrail assessment and the bedrail had been removed by RN-B. The surveyor observed the bedrail lying on the floor in the nurses office. The surveyor asked RN-B if an assessment had been done or if a conversation and planning had taken place with R2 prior to the removal of the bedrail. On August 21, 2023, at 3:11 p.m., LALD-A stated, since an assessment had not been completed, RN-B removed the bedrail. RN-B stated she reviewed risks versus benefits with R2 before removing the bedrail. LALD-A stated family (F)-H had placed the bedrail back on the bed after R2 had several recent falls at R2's request. On August 22, 2023, at 11:06 a.m., the surveyor phoned F-H and reviewed the process of the bedrail removal. F-H stated R2 requested the bedrail be put back on, as it had been put on and taken off at different times over the last few years. F-H stated he had received a phone call from office administration (OA)-G on August 21, 2023, in the afternoon, and was told the bedrail was taken off because it did not meet U.S. Food and Drug Administration (FDA) guidelines for safety.	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(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
02340	Continued From page 55 F-H stated R2 and the family wanted R2 to use a bedrail and the family was searching for another type of bedrail that the facility would allow. On August 22, 2023, at 11:25 a.m., the surveyor interviewed R2. R2 stated she had fallen out of bed, "I roll around alot at night". The surveyor asked if it was her preference to use the bedrail and R2 stated, "yes, and [sons name] wants it on there, it's his preference too. I had it on there for a night, they said I could fall through it. I've used it in the past when I first came here 5 years ago." The surveyor asked if R2 had a conversation with RN-B or LALD-A and participated in the decision to remove the bedrail and R2 stated, "I don't recall that, they just came in and took it off." The Minnesota Assisted Living Resident Bill of Rights dated November 8, 2022, indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes the opportunity to discuss care, services, treatment and alternatives with the appropriate caregivers in advance of changes. The licensee's Bill of Rights policy dated August 1, 2021, indicated assisted living staff would be trained on the concepts/rights contained in the Bill of Rights. No further information available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02340		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *08/21/23*
Time: 12:42:43
Report: 1017231190

Food and Beverage Establishment Inspection Report

Location:
Lakewood Pines Senior Housing
1702 Airport Road Ne
Staples, MN56479
Wadena County, 80

Establishment Info:
ID #: 0037557
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188944460
ID #:

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

The following orders were issued during this inspection.

3-500E Microbial Control: time as a control

3-501.19B ***** Priority 1 *****

MN Rule 4626.0408B When using time only as a public health control for up to 4 hours, discard all TCS food that has been out of temperature control for more than 4 hours; was not at 41 degrees F (5 degrees C) or less when removed from temperature control; or is in unmarked containers.

FOOD (BEEF MELT SANDWICHES) MEASURED130 DEGREES F. NINA CNA/FOOD SERVICE DETERMINED THAT FOOD WAS COOKED AT10:40 AM (CARE CENTER), THIS TIME WAS NOT RECORDED (SEE TIME CONROL PDF/FORM PDF). DISCARD FOOD BY 2:40 PM FOR COMPLIANCE OF 4 HOUR TIME HOLD.

Comply By: 08/21/23

3-500E Microbial Control: time as a control

3-501.19A ***** Priority 2 *****

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

PROVIDE WRITTEN PROCEDURE FOR TIME RATHER THAN TEMPERATURE FOR MICROBIAL CONTROL OF TCS FOODS. SEE FACT SHEETS PROVIDED.

Comply By: 08/21/23

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Type: Full
Date: *08/21/23*
Time: 12:42:43
Report: 1017231190
Lakewood Pines Senior Housing

Food and Beverage Establishment Inspection Report

Process/Item: Time/Temp (HAACP)
Temperature: 130 Degrees Fahrenheit - Location: HOT BEEF SANDWICH 2 HOURS LOCATED ON SERVING LINE (STEAM WELL)
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SLAW LOCATED ON SERVING LINE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: GRAPE JUICE LCOATED IN FRIDGE
Violation Issued: No

Process/Item: Time/Temp (HAACP)
Temperature: 132 Degrees Fahrenheit - Location: SHRIMP 2 HOURS LOCATED ON SERVING LINE (STEAM WELL)
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT FRUIT LOCATED IN FRIDGE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 168 Degrees Fahrenheit - Location: POTATOE WEDGES LOCATED ON SERVING LINE (STEAM WELL)
Violation Issued: No

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

ALL FOOD IS PREPARED AND MADE AT THE CARE CENTER. FOOD IS TRANSPORTED FROM CARE CENTER TO LAKEWOOD PINES IN CAMBRO.
LAKEWOOD PINES HAS SERVING KITCHEN WITH STEAM WELLS TO KEEP FOOD HOT. AT TIME OF INSPECTION FOOD WAS NOT KEPT TO MINIMUM TEMPERATURE REQUIREMENT OF 135 DEGREES F. TIME COULD BE USED AS MICROBIAL CONTROL FOR SAFETY WHEN MINIMUM HOT HOLD TEMPS CAN NOT BE MAINTAINED. ALL FOOD WAS DISCARDED AFTER LUNCH.
SEE ATTACHED PDF FOR TIME CONTROL PROCEDURE.

Type: Full
Date: *08/21/23*
Time: 12:42:43
Report: 1017231190
Lakewood Pines Senior Housing

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017231190 of 08/21/23.

Certified Food Protection Manager: HANNAH LENT

Certification Number: FM 40107 Expires: 08/30/23

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: _____

NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231190

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/21/23
Time In 12:42:43
Time Out

	Address	City/State	Zip Code	Telephone
Lakewood Pines Senior Housing	1702 Airport Road Ne	Staples, MN	56479	2188944460

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037557		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 08/22/23

Inspector (Signature)