Electronically Delivered

February 2, 2024

Licensee
McGregor Carefree Living LLC
22027 420th Street
McGregor, MN 55760

RE: Project Number(s) SL27287015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27287	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGREGOR CAREFREE LIVING LLC	22027 420TH STREET MCGREGOR, MN 55760

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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: SL27287015 On January 8, 2024, through January 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 residents.	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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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

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0 650	Continued From page 3 The findings include: During entrance conference on January 8, 2024, at 9:54 a.m., administrator coordinator (AC)-C stated she was responsible for employee records and assisted in new employee orientation. CNS-B CNS-B had a start date of November 29, 2023, to provide and supervise direct care services to the licensee's residents. RN-G RN-G had a start date of May 8, 2023, to provide direct care services to the licensee's residents. CNS-B and RN-G's employee records did not include evidence of orientation training included: -an introduction and review of the facility's policy and procedures related to the provision of assisted living services by the individual staff person. ULP-E ULP-E had a start date October 19, 2015, to provide direct care services to the licensee's residents. On January 8, 2024, at 1:07 p.m., the surveyor observed ULP-E administering R1's scheduled afternoon medications. ULP-E's employee record did not include evidence of annual training included: -review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.	0 650		

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0 650	Continued From page 4 On January 9, 2024, at 2:39 p.m., AC-C stated she reviews the policy and procedure book with new employees as part of orientation. AC-C stated she thought the supportive documentation of reviewing the facility's policy and procedures was on the orientation checklist for new employees. AC-C reviewed the orientation checklist and stated it was not on the form but could easily add it. AC-C stated annual training included reviewing the policy and procedure book; however, there was no documentation in employee records to support required training was completed. ULP-E stated at each staff meeting different polices were reviewed. The licensee's Training and Competency of Unlicensed Staff policy dated January 16, 2023, under Orientation and Annual Training Requirements indicated all staff providing and supervising direct services must complete an introduction and review of the facility's policy and procedures related to the provision of assisted living services by the individual staff person. The licensee would retain evidence in the employee record of each staff person having completed the orientation and training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	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:	0 780		

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0 780	Continued From page 5 (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 smoke alarms outside all sleeping rooms and interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 6 The findings include: Smoke Alarm Interconnection/ Installation Outside Sleeping Rooms On a facility tour on January 8, 2024, at 2:00 p.m., with clinical nurse supervisor (CNS)-B, regional consultant (RC)-D and maintenance (M)-F, it was observed smoke alarms were not installed in the corridors (hallways) of house #1 and interconnected to the smoke alarms in the resident rooms so activation of one alarm activates all smoke alarms throughout house #1 in the resident rooms and corridors. The smoke alarms in the resident rooms of house #1 when tested were interconnected to the smoke alarms in the other sleeping rooms. On the same tour it was also observed smoke alarms were not installed in the corridors of house #2 and interconnected to the smoke alarms in the resident rooms so activation of one alarm activates all alarms throughout house #2 in the resident rooms and corridors. The smoke alarms installed in the resident rooms of house #2 when tested were not interconnected with the smoke alarms in the other sleeping rooms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. Smoke alarms are required to be installed inside and outside in the immediate vicinity of all sleeping rooms in dwelling units. On January 8, 2024, at 2:00 p.m., M-F, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility inside and outside in the	0 780		

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0 780	Continued From page 7 immediate vicinity of the sleeping rooms. It was also verified by M-F on the tour that smoke alarms are not installed outside in the immediate vicinity of the sleeping rooms of house #1 and house #2. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 800		

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0 800	Continued From page 8 The findings include: On a facility tour on January 8, 2024, at 2:00 p.m., with maintenance (M)-F, the surveyor made the following observations of facility hazards and disrepair: There was a leak causing moisture and corrosion on floor from the boiler heating system circulating pump connection in the mechanical room of house #1. The exit sign when tested did not function as required next to resident room #16 in house #2. The entry door top hinge was loose, and the door did not close as designed and installed in resident room #4 house #1. An electrical outlet cover was missing in resident room #4 to the right of the entry door. During an interview on January 8, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-B, regional consultant (RC)-D and M-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	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;	0 810		

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0 810	Continued From page 9 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide required training on the fire safety and evacuation plan. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 10 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 January 8, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-B, regional consultant (RC)-D and maintenance (M)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing written documentation of training in the required sequence. It was stated by CNS-B that Educare Training and training based on the facility FSEP was completed by staff, but documentation was not available. During an interview on January 8, 2024, at 1:30 p.m., CNS-B stated the employee training was not documented as required but will change this practice and document as required once at hire and twice per year thereafter and separately from fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 11 (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 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01650		

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01650	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. R3's physician orders dated December 31, 2023, included orders for an ankle-foot orthosis (AFO) brace to left lower leg. R3's Treatment and Therapy Management Plan dated December 9, 2023, indicated R3 received assistance with a brace/orthotic/prosthetic device. R3's Service Checkoff List dated December 14, 2023, through January 9, 2024, indicated R3 received assistance with putting on and taking off R3's AFO brace daily. On January 9, 2024, at 8:21 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R3's medications and remove R3's AFO brace from left leg. R3's Service Plan dated December 12, 2023, lacked the following required content: -a description of the services to be provided to include assistance with AFO brace twice a day. On January 9, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-B reviewed R3's service plan and confirmed R3's service plan did not include	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27287	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGREGOR CAREFREE LIVING LLC	22027 420TH STREET MCGREGOR, MN 55760

(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
01650	Continued From page 13 R3's AFO brace and should be on the service plan. The licensee's Service Plan policy dated January 16, 2023, indicated the service plan would include: -a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications and failed to date time-sensitive medications with opened or expiration in two of two medication carts. 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	01890		

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01890	Continued From page 14 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HOUSE TWO MEDICATION CART On January 8, 2024, at 11:21 a.m., the surveyor observed the medication cart in house two with clinical nurse supervisor (CNS)-B and regional consultant (RC)-D. CNS-B stated the nurses went through the medication carts frequently looking for expired medications. CNS-B confirmed the following: -R4's Salonpas lidocaine 4% patches (pain relievers) had an expiration date of June 2023. -R5's opened dorzolamide HCl/timolol maleate eye drop (used to treat high eye pressure) had an opened date of November 15, 2023, and had and expiration date of December 15, 2023. HOUSE ONE MEDICATION CART On January 8, 2024, at 11:31 a.m., the surveyor observed the medication cart in house one with CNS-B and RC-D. CNS-B stated staff should be dating medications when opened. CNS-B confirmed the following: -R5's opened bottle of latanoprost 0.005% eye drop (used to treat high eye pressure) and Symbicort 160/4.5 micrograms (mcg) inhaler (used to treat wheezing) lacked the date the eye drop and inhaler had been opened and when the eye drop and inhaler would expire. The manufacturer's instructions for latanoprost eye drop dated August 2011, indicated once the bottle was opened it may be stored at room temperature for six weeks.	01890		

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01890	Continued From page 15 The manufacturer's instructions for Symbicort inhaler dated December 2017, indicated to throw away Symbicort three months after removal of its foil pouch. The licensee's Storage of Medications policy dated January 16, 2023, indicated all medications stored outside of the resident's private living space would be stored according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 16 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on September 26, 2023, and was discharged on October 25, 2023. R1's diagnoses included lymphedema (swelling caused by a blockage in the lymphatic system generally in the arms or legs). R1's Discharge Summary dated October 25, 2023, indicated R1 received medication management services and at the time of discharge, all medications were sent with family. R1's October 2023, Medication Administration Summary indicated R1 received the following scheduled medications: -potassium chloride 20 milliequivalent (mEq) twice a day for supplementation; -Flonase 50 microgram (mcg) nasal spray daily	01910		

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	27287	A. BUILDING: _____ B. WING _____	01/09/2024

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01910	Continued From page 17 for allergy relief; -metoprolol tartrate 50 milligrams (mg) daily for high blood pressure; -Mucinex 600 mg one tablet twice a day for allergies; -warfarin sodium 1 mg tablet Sunday, Monday, Tuesday, Saturday and 2 mg rest of the days for thinning the blood; and -vitamin D3 50 mcg one capsule daily. R1's prescriber orders dated September 25, 2023, included all the above noted medications. R1's record did not include a disposition of medications to include the medication name, strength, prescription number as applicable, quantity, and names of other individuals involved in the disposition. On January 8, 2024, at 11:31 a.m., administrative coordinator (AC)-C stated R1 was discharged to a higher-level of care facility and all of R1's medications were sent with R1 so there would be no medication disposition record. On January 8, 2024, at 12:53 p.m., regional consultant (RC)-D provided the surveyor with R1's discharge records and stated there was no documentation in R1's record of the medications sent with R1. RC-D stated a disposition record was required for all discharges including resident transfers. The licensee's Disposal of Medication policy dated January 16, 2023, upon discharge, the licensee would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, method of disposition, to whom the medications were given, date of	01910		

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01910	Continued From page 18 disposition, and names of staff and other individuals involved in the disposition. A summary of the medication destruction/disposition would be put in the progress note of discharge summary. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, unlicensed personnel (ULPs) were trained in the proper methods to	01950		

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01950	Continued From page 19 perform the task or instructions, specified in writing for each resident, and documented those instructions in the resident's record for one of one resident (R3) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left non-dominant side. R3's physician orders dated December 31, 2023, included orders for an ankle-foot orthosis (AFO) brace to left lower leg. R3's Treatment and Therapy Management Plan dated December 9, 2023, indicated R3 received assistance with a brace/orthotic/prosthetic device. R3's Service Checkoff List dated December 14, 2023, through January 9, 2024, directed staff to assist resident with left leg AFO daily. R3's record did not include written instructions for the use of R3's AFO brace. On January 9, 2024, at 8:21 a.m., the surveyor observed unlicensed personnel (ULP)-E remove	01950		

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01950	Continued From page 20 R3's AFO brace from left leg. ULP-E stated there were no written instructions or training specifically for R3's AFO brace and she had previous experience working with AFO braces. On January 9, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated instructions for how to operate braces were in a skills book in the office. CNS-B stated staff were not specially trained on R3's AFO brace and there were no written instructions specifically for R3's AFO brace. The licensee's Delegation of Nursing, Treatment or Therapy Tasks policy dated January 16, 2023, indicated an RN may delegate nursing services to unlicensed staff only after determining the ULP was trained and competent and had been instructed in the proper methods to perform the procedures with respect to the specific resident and written instructions for performing the procedure were in the resident's record. The licensee's Treatment and Therapy Management policy dated January 16, 2023, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -documentation of specific resident instructions relating to the treatments or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01950		

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

Type: Full
Date: *01/09/24*
Time: 10:20:00
Report: 1006241008

Food and Beverage Establishment Inspection Report

Location:
Mcgregor Carefree Living Llc
22027 420th Street
McGregor, MN55760
Aitkin County, 01

Establishment Info:
ID #: 0039111
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2187683356
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.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT USES QUAT TABLETS AND A QUAT AMMONIA THAT THEY MIX IN SANITIZER SPRAY BOTTLES, BUT DO NOT HAVE QUAT TEST STRIPS. DISCUSSED PROVIDING QUAT TEST STRIPS TO ENSURE PROPER LEVELS ARE BEING MET AT ALL TIMES, 200-400 PPM.

Comply By: 01/23/24

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

ONE OF THE SMALLER TEFLON PANS WAS BADLY SCRATCHED UP AND THE COATING WAS FLAKING. PAN WAS REMOVED FROM THE KITCHEN IMMEDIATELY.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY
Violation Issued: No

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

Hot Water: = at 179F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Homestyle Refrigerator/fre
Temperature: 41 Degrees Fahrenheit - Location: AU GRATIN POTATOES
Violation Issued: No

Process/Item: Homestyle Refrigerator/fre
Temperature: 38 Degrees Fahrenheit - Location: EGG SALAD
Violation Issued: No

Process/Item: Homestyle Refrigerator/fre
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: SHEPARDS PIE
Violation Issued: No

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

Process/Item: Homestyle Refrigerator/fre
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Homestyle Refrigerator/fre
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: PIE FILLING
Violation Issued: No

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

COMMENTS:

INSPECTION ACCOMPANIED BY BEN CASTAGNERI AND SARA MORLANG.

THE DISH MACHINE ON ONE SIDE AND AN UPRIGHT REFRIGERATOR WERE NOT IN USE AT THE TIME OF THE INSPECTION. FACILITY IS IN THE PROCESS OF HAVING THEM REPAIRED OR REPLACED AND ALTERNATIVE MEASURES ARE IN PLACE. A FACE PLATE WAS ALSO MISSING OFF AN ELECTRICAL OUTLET THAT THE TOASTER WAS PLUGGED INTO, STAFF ARE AWARE OF IT AND ARE WORKING ON REPLACING THIS.

OBSERVED GOOD HAND WASHING AND NO BARE HAND CONTACT WITH READY TO EAT FOODS DURING THE INSPECTION. DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND EXCLUSION OF BARE HAND CONTACT WITH ALL READY TO EAT FOODS BY USING GLOVES, TONGS, DELI TISSUE, ETC.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY SUSPECTED FOODBORNE ILLNESS COMPLAINTS.

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 1006241008 of 01/09/24.

Certified Food Protection Manager: Sara L. Morlang

Certification Number: FM104334 Expires: 06/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ben Castagneri
Dining Services Director

Signed: _____

Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006241008

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

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

Date 01/09/24
Time In 10:20:00
Time Out

Mcgregor Carefree Living Llc	Address: 22027 420th Street	City/State: McGregor, MN	Zip Code: 55760	Telephone: 2187683356
License/Permit #: 0039111	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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

		Compliance Status			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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used	X	
48	X	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:** 01/11/24

Inspector (Signature)