



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 3, 2024

Licensee

Wesley Residence Of Duluth

5601 Grand Avenue

Duluth, MN 55807

RE: Project Number(s) SL30422015

Dear Licensee:

On April 24, 2024, 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 February 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 23, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 23, 2024, found not corrected at the time of the April 24, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on April 24, 2024 (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.

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.

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.

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.

To submit a reconsideration request, please visit:

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

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,

A handwritten signature in cursive script that reads "Jessica Chenze".

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30422	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2024
NAME OF PROVIDER OR SUPPLIER WESLEY RESIDENCE OF DULUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5601 GRAND AVENUE DULUTH, MN 55807		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL30422015-1 On April 23, 2024, through April 24, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 23, 2024. At the time of the survey, there were 30 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	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}			
{0 780} SS=D	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	{0 780}			

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{0 780}	Continued From page 2 by: No further action required.	{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: No further action required.	{0 800}			
{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	{0 810}			

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{0 810}	Continued From page 3 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: No further action required.	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}			

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{0 820}	Continued From page 4 This MN Requirement is not met as evidenced by: No further action required.	{0 820}			
{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 date time-sensitive medications with opened or expiration dates for R14, R15. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION CART C On April 23, 2024, at 10:07 a.m., the surveyor observed medication C cart with clinical nurse supervisor (CNS)-B. CNS-B stated staff have been trained to date insulins, inhalers and eye	{01890}			

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{01890}	Continued From page 5 drops when opened and to use the medications within the recommended time frame and medication carts were audited weekly for expired medications. CNS-B confirmed the following: -R15's opened Humalog Kwik insulin pen and Lantus Solostar insulin pen (fast acting insulin) lacked the date the insulin pens had been opened and when the insulin pens would expire. MEDICATION CART B On April 23, 2024, at 10:18 a.m., the surveyor observed medication cart B with CNS-B. CNS-B confirmed the following: -R14's Ozempic injection pen (injection to help the pancreas make more insulin to reduce blood sugar) lacked the date the injection pen was opened and when the injection pen would expire. The manufacturer's instructions for Humalog KwikPen dated November 2019, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Ozempic injection pen dated 2022, indicated to toss the injection pen eight weeks after start of use. The licensee's Storage of Medication policy dated December 22, 2021, indicated a drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drugs, directions for use, client's name, prescriber's name, date of issue and the name	{01890}			

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{01890}	Continued From page 6 and address of the licensed pharmacy that issued the mediations. No further information was provided.	{01890}			



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Electronically Delivered

March 14, 2024

Licensee

Wesley Residence of Duluth

5601 Grand Avenue

Duluth, MN 55807

RE: Project Number(s) SL30422015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 23, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has

been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

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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: SL30422015 On February 20, 2024, through February 23, 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 33 residents receiving services under the Assisted Living license. Immediate correction orders were identified on February 22, 2024, and February 23, 2024, issued for SL30422015, tag identifications 1290 and 1750 respectfully. On February 23, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained at a scope and level of I. On February 26, 2024, the immediacy of correction order 1750 was removed, however		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.	

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies	0 100			

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0 100	Continued From page 2 the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they applied for licensure for the assisted living license despite sharing one roof with an adjoining building, without having an approved two-hour fire wall. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee's health facility identification (HFID) 3042, a building, was located at 5601 Grand Avenue, Duluth, MN 55811, was attached to other occupancies under the same roof in the same building. On February 22, 2024, at 8:29 a.m., the Minnesota Department of Health (MDH) engineering survey staff emailed licensed assisted living director (LALD)-A and stated a two-hour fire barrier wall was required by assisted	0 100			

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0 100	Continued From page 3 living licensing to separate this assisted living from other occupancies under the same roof in the same building. Engineering survey staff requested LALD-A provide documentation the walls separating this assisted living from other occupancies within the same building are two-hour fire barrier walls. On February 22, 2024, at 8:30 a.m., LALD-A, stated the email was forwarded to executive director (ED)-O and maintenance (M)-G to help with this request because LALD-D did not know if the wall was constructed as a two-hour fire barrier. On February 23, 2024, at 11:42 a.m., engineering staff sent an email to LALD-A, as a follow up to inquire if ED-O and M-G were able to find documentation the walls separating this assisted living from other occupancies in the same building were two-hour fire barrier walls. On February 23, 2024, at 11:44 a.m., LALD-A responded by email stating LALD-A had not heard from ED-O or M-G yet and would follow up with them. On February 23, 2024, at 11:52 a.m., LALD-A responded by email stating ED-O would need to consult with their architect on February 26, 2024, to verify the type of wall construction of the wall separating this assisted living from other occupancies in the same building. LALD-A indicated she would inform engineering staff if she heard anything. On February 29, 2024, at 3:36 p.m., the surveyor sent a follow up email to LALD-A to inquire if any more information was available regarding the required two-hour fire barrier wall separating this	0 100			

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0 100	Continued From page 4 assisted living from other occupancies in the same building. On March 1, 2024, at 1:31 p.m., LALD-A responded and indicated she forwarded the email to ED-O again and LALD-A was informed they will be meeting with the architect at this assisted living on March 4, 2024. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	0 250			

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0 250	Continued From page 5 files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had	0 250			

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0 250	Continued From page 6 the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 20, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with	0 250			

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0 250	Continued From page 7 these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page six was electronically signed by the authorized agent on January 29, 2024. The licensee had an assisted living license,	0 250			

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0 250	Continued From page 8 effective April 1, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs; - conducting appropriate screenings, or documentation of prior screenings, to show that staff were free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention of Standards; - supervision of unlicensed personnel; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; and - medication and treatment management. As a result of the survey, the following correction orders were issued, 0100, 0480, 0490, 0550, 0660, 0730, 0780, 0800, 0810, 0820, 1060, 1290, 1350, 1370, 1380, 1440, 1550, 1700, 1750, 1760, 1890, and 1950, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			

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0 480	Continued From page 9	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 20, 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			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490			

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0 490	Continued From page 10 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 33 residents of 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) 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).	0 490			

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0 490	Continued From page 11 The findings include: During the entrance conference on February 20, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee employed one part-time staff for activities who worked Monday, Wednesday, and Fridays. CNS-B stated she was unsure if there were activities or events planned for residents on the days activity coordinator (AC) was not working. CNS-B stated there was no activity calendar posted or provided to the residents. During the facility tour on February 20, 2024, at 11:42 a.m., with CNS-B and registered nurse (RN)-C, the evaluator did not observe an activity or event calendar posted throughout the building. On February 23, 2024, at 8:20 a.m., AC-N stated she worked Monday, Wednesday, and Fridays. AC-N stated she did not plan resident activities or events on the days she was not working including weekends. AC-N stated she did not create a monthly activity calendar for the residents and residents were informed of an activity either by a sign-up sheet on her door or in person on the day of the activity. On February 23, 2024, at 2:29 p.m., licensed assisted living director (LALD)-A stated she was unaware the licensee was required to have at least one social or recreational activity scheduled daily. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			

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0 550	Continued From page 12	0 550			
0 550 SS=D	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to follow their Resident Grievance policy and procedure for one of one resident (R6) who filed a written complaint. 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:	0 550			

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0 550	Continued From page 13 R6's diagnoses included diabetes type II, schizo-affective disorder, and anxiety. R6's Service Plan dated March 1, 2024, indicated R6 received assistance with dressing, grooming, bathing, transfer/ambulation, medication administration, laundry, and housekeeping. R6's 90-Day Assessment dated December 6, 2023, indicated R6 had impaired judgement and was at risk to be abused by others. R6's written grievance dated September 21, 2023, indicted on September 14, 2023, at approximately 8:00 p.m., unlicensed personnel (ULP)-K arrived at R6's room to administer medications. R6 asked ULP-K how much insulin she would be administered. ULP-K did not respond. R6 became upset and swore at ULP-K and asked ULP-K again, how much insulin R6 would be receiving. ULP-K replied to R6 that ULP-K could deny R6's medications because R6 yelled at her and left R6's rooms without administering R6's insulin and did not return. R6's Progress Note dated September 21, 2023, at 10:39 a.m., indicated licensed assisted living director (LALD)-A received a written concern from R6's caregiver from an outside provider. The concern was about ULP-K who was staff from a contracted agency. Clinical nurse supervisor (CNS)-B spoke with R6 regarding the concern and housing manager (HM)-Q would follow up with R6 on September 26, 2023 for additional documentation. R6's record lacked documentation R6 received a written response to R6's grievance, a formal written summary to the resolution, or documentation the reason the resolution plan for	0 550			

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0 550	Continued From page 14 was delayed. On February 21, 2024, at 1:00 p.m., CNS-B stated she talked to R6 about the incident with ULP-K but did not document the conversation with R6 or resolution to the complaint. The licensee's Resident Grievance policy dated February 2023, indicated within 14 calendar days, management would provide formal response to the grievance. In 30 calendar days all complaints/grievances would be resolved through a formal written summary to include: -the nature of the complaint and the date it was received; -the results of the complaint review; and -the complaint resolution, including any corrective action. If for some reason the complaint could not be completed within 30 calendar days, the program would document the reason for delay and a plan for resolution. The complaint summary and resolution would be maintained in the person's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550			
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660			

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0 660	Continued From page 15 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of three employees (unlicensed personnel (ULP)-D, ULP-E, ULP-H). 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 February 20, 2024, at 9:50 a.m., clinical nurse supervisor	0 660			

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NAME OF PROVIDER OR SUPPLIER WESLEY RESIDENCE OF DULUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5601 GRAND AVENUE DULUTH, MN 55807		
(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
0 660	Continued From page 16 (CNS)-B stated TB history screen and baseline TST screenings were completed at employee hire. The facility's TB risk assessment was completed on September 14, 2023, and the facility was determined to be a low risk level. ULP-D ULP-D was hired on August 30, 2023, to provide direct care services to the licensee's residents. On February 20, 2024, at 2:12 p.m., the surveyor observed ULP-D provide scheduled morning medication administration to R1. ULP-D's employee record included documentation of a negative TST on June 2, 2023; however, lacked a baseline TB screening for active TB and a second step TST had been completed. ULP-E ULP-E was hired on March 14, 2023, to provide direct care services to the licensee's residents. On February 21, 2024, at 7:22 a.m., the surveyor observed ULP-E provide scheduled morning medication administration to R5. ULP-E's employee record included documentation of a negative TST on February 5, 2024; however, lacked a baseline TB screening for active TB and documentation a two-step TST had been completed. ULP-H ULP-H was hired October 11, 2023, to provide direct care services to the licensee's residents.	0 660			

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0 660	Continued From page 17 ULP-H's employee record included a baseline TB screening for active TB; however, lacked a two-step TST or other evidence of TB screening had been completed. On February 21, 2024, at 12:21 p.m., licensed assisted living director (LALD)-A stated ULP-H completed a baseline TB screening; however, did not complete a two-step TST or other blood test at hire. On February 22, 2024, at 9:19 a.m., LALD-A stated ULP-D and ULP-E were contracted agency staff and was just informed the contracted agency staff do not receive a two-step TST and only receive one of the required two-steps TST. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated at the time of hire and prior to any contact with residents, all assisted living employees and volunteers would be screened for TB. The RN would review TB symptoms with each new assisted living employee and with any volunteers having direct resident contact. Each staff would be screened for TB, a two-step skin test or single interferon gamma release assay (IGRA) would be administered unless the person's past medical history indicates that a TB skin test was contraindicated. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a	0 660			

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0 660	Continued From page 18 negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730			

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0 730	Continued From page 19 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional for one of one resident (R2) with a medication error. 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	0 730			

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0 730	Continued From page 20 situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, chronic kidney disease stage three, depression, epilepsy, and long-term use of insulin. R2's Service Plan dated August 3, 2023, indicated R2 received medication administration assistance eight times a day. R2's Medication Management Plan dated November 22, 2023, indicated staff would administer all medications. R2's Individual Abuse Prevention Plan and Assessment dated November 27, 2023, indicated R2 required assistance with medications and was at risk to be abused (physically, verbally, financially, and/or sexually). R2's progress note dated February 16, 2024, at 9:17 a.m., indicated R2 was given another resident's medications. R2's medications were held, clinical nurse supervisor (CNS)-B called the pharmacist and R2's BP was to be monitored every four hours. R2's blood pressure report dated February 15, 2024, through February 17, 2024, lacked documentation R2's blood pressure was monitored on February 16, 2024, as directed by CNS-B. R2's record lacked an incident report was completed for the medication error that occurred on February 16, 2024, by unlicensed personnel (ULP)-D.	0 730			

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0 730	Continued From page 21 On February 23, 2024, at 9:54 a.m., CNS-B stated she was working the morning R2 received the wrong medications and consulted with R2's pharmacist. CNS-B and R2's pharmacist reviewed the wrong medications R2 received, and the pharmacist directed to monitor R2's blood pressure. CNS-B stated she gave verbal instructions for ULP-D to monitor R2's blood pressure every four hours. CNS-B reviewed R2's recorded blood pressures from February 15, 2024, through February 17, 2024, and stated there were no documented blood pressures for R2 on February 16, 2024, the day of the incident. CNS-B stated she did not complete a medication incident report for ULP-D's medication error and stated she didn't think about it at the time of the incident and should have completed an incident report. CNS-B stated she did notify R2's primary care provider because the nurse practitioner was onsite frequently and was going to inform at that time. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	0 730			
0 780 SS=D	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	0 780			

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0 780	Continued From page 22 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 in the immediate vicinity of all sleeping rooms in the facility. This had the potential to directly affect a limited number of 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on February 21, 2024, at 10:15 a.m., with maintenance (M)-G, it was observed that smoke alarms were not provided in resident sleeping room number 4.	0 780			

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0 780	Continued From page 23 All sleeping units are required to be provided with smoke alarms within the sleeping unit. During the tour M-G, stated they had installed a smoke alarm in resident room number 4 recently, but the resident must have removed the alarm since it was installed. TIME PERIOD FOR CORRECTION: One (1) day.	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	0 800			

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0 800	Continued From page 24 a large portion or all of the residents). Findings include: On a facility tour on February 21, 2024, at 10:20 a.m., with maintenance (M)-G, the surveyor made the following observations of facility hazards and disrepair: There was a smoke alarm installed but when tested by M-G the alarm did not activate in resident sleeping room number 227. As required by Minnesota Fire Code in Minnesota Rules Chapter 7511, sleeping unit smoke alarms are required to be maintained in accordance with manufactures instructions and replaced every ten years. The emergency light did not operate when the test button was pushed inside the stairway near resident room number 232. Exit lighting is required to be maintained as required by Minnesota Fire Code in Minnesota Rules Chapter 7511. An exterior means of egress emergency light was broken with no bulbs and hanging on the electrical wires outside the second-floor exit door near resident sleeping room number 215. The marked exit door was provided with a barrel bolt sliding lock on the egress side of the door leading to the stairway from the basement near the door marked sprinkler equipment room. Marked exit doors are required to be maintained with approved locks or latches installed and maintained in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. Storage of laundry carts was observed in the	0 800			

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0 800	Continued From page 25 lower-level exit corridor near the stairway next to the door marked sprinkler equipment room. Means of egress corridors are required to be kept free of storage for immediate and unobstructed use of the exit in the event of a fire or similar emergency in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. Ceiling tiles were missing in the laundry room in the lower level. Ceiling tiles are required to be maintained in place in buildings provided with a fire sprinkler system in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. A strong odor of urine and a large stain in the carpet of resident sleeping room number 4 was observed. The odor of urine from resident room number 4 was present in the corridor outside the room and scented dryer sheets were placed in the corridor to help mask the odor of urine. A condensation leak was observed on the exhaust vent for the boiler on the left when facing the boilers in the boiler room. Boiler vents are required to be maintained free of leaks as installed and designed at the time of construction. During a facility tour on February 21, 2024, at 11:15 a.m., M-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810			

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0 810	Continued From page 26 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to	0 810			

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0 810	Continued From page 27 directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 21, 2024, at 9:30 a.m., licensed assisted living director (LALD)-A, 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 providing written documentation training was provided one time in 2023 in April. During an interview on February 21, 2024, at 10:00 a.m., LALD-A stated the only written documentation available for the required employee training was for April 2023. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing written documentation drills were completed 1 time in 2022 on June 24, 2022, and 3 times in 2023 on	0 810			

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0 810	Continued From page 28 March 2, 2023, September 17, 2023, and November 19, 2023. During an interview on February 21, 2024, at 10:10 a.m., LALD-A stated the only written drill documentation available was for June 24, 2022, March 2, 2023, September 17, 2023, and November 19, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. 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	0 820			

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0 820	Continued From page 29 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 21, 2024, at 11:00 a.m. with maintenance (M)-G, it was observed that used cigarette butts were discarded on the carpeted floor of resident sleeping room number 4. Used smoking materials are required to be disposed of in appropriate containers located at the designated smoking area in accordance with the licensee smoking policy. These deficient conditions were visually verified by M-G accompanying on the tour. TIME PERIOD FOR CORRECTION: one (1) day	0 820			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060			

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01060	Continued From page 30 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R4) reviewed for a hospitalization.	01060			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WESLEY RESIDENCE OF DULUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5601 GRAND AVENUE DULUTH, MN 55807		
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01060	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4's diagnoses included human immunodeficiency virus (HIV). R4's progress note indicated on October 16, 2023, R4 was admitted to the hospital. On November 3, 2023, R4's progress note indicated R4 was discharged from the hospital and admitted to a short-term rehabilitation facility. R4's record did not include a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 32 In addition, R4's record did not include notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On February 21, 2024, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated she was not aware of the requirements that a written notice of emergency relocation with the above noted content needed to be provided to the resident and/or resident's representative and notification to the ombudsman was required for a hospital stay of four days or greater. The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice which would include: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider, contact information for the OOLTC, if known the approximate date/date range when resident was expected to return or a statement that a return date is not currently known; and if the facility refuses to provide housing or services after relocation, the resident has the right to appeal and who to contact to proceed with the appeal. If the resident has not returned to the facility within four days, the Ombudsman would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290			

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01290	Continued From page 33 (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 background clearance studies were conducted for six of seven contracted agency employees (unlicensed personnel (ULP)-D, ULP-E, ULP-I, ULP-J, ULP-L, ULP-M). In addition, the licensee failed to ensure a background study was submitted and clearance was received in affiliation with the assisted living license for one of two employees (clinical nurse supervisor (CNS)-B). This had the potential to affect all 33 residents. 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).	01290			

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01290	Continued From page 34 The findings include: During entrance conference on February 20, 2022, at 9:50 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated the ULPs worked 12 hour shifts from 6:00 a.m., to 6:00 p.m. LALD-A stated the licensee has been using ULPs from a contracted agency since COVID-19. The surveyor requested a list of employees including all contracted agency staff. NO BACKGROUND STUDIES On February 21, 2024, at 6:35 a.m., ULP-D, ULP-E, and ULP-I stated they were all working the day shift and were all contracted employees by [agency name]. ULP-E stated she was working medication cart C, ULP-D stated she was working medication cart B, and ULP-I stated she was working medication cart A. On February 21, 2024, at 7:00 a.m., to 8:20 a.m., the surveyor observed ULP-D, ULP-E, and ULP-I administering several residents their scheduled morning medications. During the time of the medication observation, the ULPs were not under direct supervision. ULP-D had a hire date of August 30, 2023, to provide assisted living services to the licensee's residents. ULP-E had a hire date of March 14, 2023, to provide assisted living services to the licensee's residents. ULP-I had a hire date of May 9, 2022, to provide assisted living services to the licensee's residents.	01290			

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01290	Continued From page 35 ULP-J had a hire date of November 29, 2023, to provide assisted living services to the licensee's residents. ULP-L had a hire date of March 17, 2022, to provide assisted living services to the licensee's residents. ULP-M had a hire date of February 21, 2024, to provide assisted living services to the licensee's residents. ULP-D, ULP-E, ULP-I, ULP-J, ULP-L, ULP-M's employee records lacked evidence of a background clearance in NETStudy 2.0 was completed as required. On February 22, 2024, at 10:58 a.m., licensed assisted living director (LALD)-A stated she was unaware the reports provided by the contracted agency were not background study clearances and confirmed the ULPs listed above were all active contracted employees and either have worked or were currently on the staff working schedule. NON-AFFILIATED BACKGROUND STUDY CNS-B was hired on August 5, 2022, to provide direct care services to the licensee's residents. CNS-B's employee record included background study clearance letter dated August 5, 2022, affiliated to ownership umbrella HFID 30521 for another facility. CNS-B's record lacked evidence the licensee submitted a background study for CNS-B was affiliated to the licensee's HFID number. On February 21, 2024, at 11:03 a.m., LALD-A verified CNS-B's background study clearance	01290			

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01290	Continued From page 36 was affiliated with the licensee's other assisted living and not under current assisted living licensee. The licensee's undated Background Checks policy indicated all employees as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact would undergo a background study through the Department of Human Services (DHS). Only those with satisfactory results would continue to work with the facilities residents. Employees, contractor, and regularly scheduled volunteers of the facility are subject to background study required by section 144.057 and may be disqualified under chapter 245C. Per 144G.60, Subd. 5. Temporary staff. When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. Per 144G.60, Subd 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. Per 144.057, Subd. 1 (4) the commissioner of health shall contract with the commissioner of human services to conduct background studies of: (4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities;	01290			

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01290	Continued From page 37 Per 245C.02, Subd. 13d. NETStudy. "NETStudy" means the commissioner's online system implemented in July 2004 and used by entities for submitting background study requests required under this chapter. Per 245C.02, Subd. 13 e. NETStudy 2.0. "NETStudy 2.0" means the commissioner's system that replaces both NETStudy and the department's internal background study processing system. NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by improving the accuracy of background studies through fingerprint-based criminal record checks and expanding the background studies to include a review of information from the Minnesota Court Information System and the national crime information database. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's onsite observation on February 23, 2024, and review by evaluation supervisor on February 23, 2024, however non-compliance remains at a scope and level of three, widespread (I).	01290			
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility.	01350			

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01350	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation, as identified in 144G.60, Subd. 4 and 144G.61 Subd 1. and 2, for seven of seven unlicensed personnel (ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, ULP-L, ULP-M). This had the potential to affect all 33 residents receiving medication and treatment services. 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). The findings include: During entrance conference on February 20, 2022, at 9:50 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C stated the ULPs worked 12-hour shifts from 6:00 a.m. to 6:00 p.m. Licensed assisted living director (LALD)-A stated the licensee has been using ULPs from a contracted agency since COVID-19. The surveyor requested a list of employees including all contracted agency staff. On February 21, 2024, from 7:00 a.m. to 8:20 a.m., the surveyor observed ULP-D, ULP-E, and ULP-I administering several residents their scheduled morning medications and treatments. During the time of the medication observation, the ULPs were not under direct supervision.	01350			

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01350	Continued From page 39 R5's February 2024 Medication Administration Summary indicated ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, ULP-L, and ULP-M provided medication and treatment services to R5. ULP-D had a hire date of August 30, 2023, to provide assisted living services to the licensee's residents. ULP-E had a hire date of March 14, 2023, to provide assisted living services to the licensee's residents. ULP-I had a hire date of May 9, 2022, to provide assisted living services to the licensee's residents. ULP-J had a hire date of November 29, 2023, to provide assisted living services to the licensee's residents. ULP-K had a hire date of March 17, 2022, to provide assisted living services to the licensee's residents. ULP-L had a hire date of March 17, 2022, to provide assisted living services to the licensee's residents. ULP-M had a hire date of February 21, 2024, to provide assisted living services to the licensee's residents. ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, ULP-L, ULP-M's employee records lacked evidence ULP-D, ULP-E, ULP-I, ULP-J, ULP-K, ULP-L, and ULP-M received required training and completed competency evaluations by the licensee's RN before providing services to the licensee's	01350			

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01350	Continued From page 40 assisted living residents. On February 21, 2024, at 12:10 p.m., LALD-A stated agency contracted staff receive a facility tour and are trained on RTasks (electronic medical record system) if needed. LALD-A stated the licensee's RN does not complete training or competency evaluations with the agency staff because the staff the agency provided should have already trained and ready to go. On February 21, 2024, at 1:00 p.m., CNS-B stated she did not handle agency staff and was unaware agency staff had to be trained and demonstrate competency by the licensee's RN in mediation, treatment and therapy services that would be provided to the licensee's residents. CNS-B stated she thought the agency staff already received the required training needed to work at assisted living facilities. The licensee's undated Training ULP for Medication, Treatment, and Therapy Administration policy indicated before the RN delegated the task of medication administration, treatment and therapy, the RN would instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent. The RN would document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350			

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01370	Continued From page 41	01370			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370			

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01370	Continued From page 42 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H had a start date of October 11, 2023, to provide direct care under the licensee's assisted living license. R5's February Medication Administration Summary indicated on February 11, 2024, ULP-H administered R5's scheduled morning medications. ULP-H's employee record lacked ULP-H received the following training and/or competency evaluations: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming including: hair care and bathing, care of teeth, gums, an oral prosthetic	01370			

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01370	Continued From page 43 devices, care an use of hearing aids, dressing and assisting with toileting; -standby assistance techniques and how to perform them; and -understanding appropriate boundaries between staff and clients and the client's family. On February 22, 2024, at 2:52 p.m., clinical nurse supervisor (CNS)-B stated she had not been completing the orientation checklist with new employees or competency evaluations. CNS-B stated she did not provide training or complete required competency evaluations for ULP-H. On February 22, 2024, at 3:19 p.m., licensed assisted living director (LALD)-A stated the nurse would sit down with new employees after they completed their assigned training in Educare (electronic training program), ask if they had any questions and provide any additional training if needed. LALD-A stated the nurse did not have the new employees complete a return demonstration all the required areas and would randomly pick a task for the new employee to demonstrate on a doll. If the new employee completed the return demonstration correctly, the nurse would sign off that all trainings and competencies were completed. On February 22, 2024, at 3:36 p.m., during a telephone interview, ULP-H stated she did not receive any formal training except what was assigned in Educare. ULP-H stated she did not complete competency evaluations with the registered nurse (RN) before working with the licensee's residents. ULP-H stated she received training by working with other ULPs. The licensee's Employee New Hire and Training Procedure policy dated January 2016, indicated	01370			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30422	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2024
NAME OF PROVIDER OR SUPPLIER WESLEY RESIDENCE OF DULUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 GRAND AVENUE DULUTH, MN 55807			
(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
01370	Continued From page 44 upon hire all staff would go through an orientation and training process per position and include one or more of the following components/Educare trainings: -OSHA and infection control; -basic maintenance -housekeeping, laundry and bed making; -personal care; -client mobility, exercise, ambulation, lifting and safe transfers, ROM, positioning; and -a return demonstration of delegated tasks with an RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.	01380			

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01380	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H had a start date of October 11, 2023, to provide direct care under the licensee's assisted living license. R5's February Medication Administration Summary indicated on February 11, 2024, ULP-H administered R5's scheduled morning medications. ULP-H's employee record lacked ULP-H received the following training and/or competency evaluations: -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments as required; and -other RN/professionally delegated tasks (i.e., monitoring vital signs and catheter). On February 22, 2024, at 2:52 p.m., clinical nurse supervisor (CNS)-B stated she had not been	01380			

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01380	Continued From page 46 completing training or competency evaluations with ULPs. CNS-B stated she did not provide training or complete competency evaluations for ULP-H noted above. On February 22, 2024, at 3:19 p.m., licensed assisted living director (LALD)-A stated the nurse would sit down with new employees after they completed their training in Educare (computer training program) ask if they had any questions and provide any additional training if needed. LALD-A stated the nurse did not have the new employees complete a return demonstration all the required areas and would randomly pick a task for the new employee to demonstrate. If the new employee completed the return demonstration correctly, the nurse would sign off that all trainings and skills were completed. On February 23, 2024, at 3:36 p.m., during a telephone interview, ULP-H stated she did not receive any formal training except what was assigned in Educare (electronic based training program). ULP-H stated she did not have to demonstrate competency evaluations to the registered nurse (RN) before working with the licensee's residents and received on the job training by other ULPs. The licensee's Employee New Hire and Training Procedure policy dated January 2016, indicated upon hire all staff would go through an orientation and training process per position and include one or more of the following components/ Educare trainings: -client mobility, exercise, ambulation, lifting and safe transfers, ROM, positioning; -medication assistance and administration; and -a return demonstration of delegated tasks with an RN.	01380			

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01380	Continued From page 47 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which	01440			

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01440	Continued From page 48 the individual begins working for the licensee for one of one unlicensed personnel (ULP)-H. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H had a start date of October 11, 2023, to provide direct care services to the licensee's assisted living residents. On February 21, 2024, at 12:21 p.m., licensed assisted living director (LALD)-A stated there was no documentation indicating a registered nurse (RN) completed a 30-day supervision of a delegated task for ULP-H. The licensee's undated Supervision of Unlicensed Personal policy indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy services must be performed within 30 days after the person begins work for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			

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01550	Continued From page 49	01550			
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (cook (C)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: C-F was hired on October 1, 2012, under the comprehensive home care license and began providing assisted living services on August 1, 2021. During the survey, the surveyor observed C-F prepare and service resident meals.	01550			

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01550	Continued From page 50 C-F's training records indicated C-F completed 1.5 hours out of the required two hours of dementia training in the year 2023. On February 21, 2024, at 11:06 a.m., licensed assisted living director (LALD)-A stated corporate was responsible for assigning employee training. LALD-A verified C-F's training transcript indicated C-F only had 1.5 hours of dementia training and should have had a minimum of two hours annually. The licensee's undated Assisted Living Dementia Care Training policy indicated non-direct care staff would complete a minimum of two hours of training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	01700			

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01700	Continued From page 51 medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R3) who self-administered insulin after set up. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included diabetes type II, schizophrenia, and paranoia with hallucinations. R3's Service Plan dated February 8, 2021, indicated R3 received assistance with	01700			

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01700	Continued From page 52 medications. R3's prescriber orders dated March 30, 2023, included an order for Novolog Flexpen (rapid-acting insulin) to inject 0 to 12 units depending on blood glucose (sugar in the blood) three times a day with a meal. R3's 90-Day Assessment dated November 21, 2023, indicated R3 required assistance with medications including insulin and staff were to administer insulin as prescribed. On February 21, 2024, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-D observe R3 check his own blood glucose with his blood glucose meter and ULP-D recorded the results of 197 milligrams per deciliter (mg/dl). ULP-D stated R3 would receive three units of Novolog insulin. ULP-D did not prime the insulin pen prior to dialing the pen to three units, handed the insulin pen to R3 injected three units of Novolog into his right abdomen area. On February 21, 2024, at 7:35 a.m., immediately following the above noted observations, ULP-D stated R3 was able to check his own blood glucose and administer own insulin. On February 23, 2024, at 1:23 a.m., licensed assisted living director (LALD)-A stated R3 was able to administer own insulin and check his own blood glucose. LALD-A stated she was unaware a medication assessment was necessary when staff were dialing the insulin dose and R3 injected the insulin while staff observed. The licensee's Medication Management policy dated January 1, 2020, indicted the registered nurse (RN) would determine which medication	01700			

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01700	Continued From page 53 management services the licensee would offer. Based of the nursing assessment, the RN would develop an individualized medication management plan for each resident receiving any type of medication management services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, unlicensed personnel (ULP)-D received training and demonstrated competency for administering medications. In addition, the licensee failed to ensure specific instructions were in the resident record related to administering medications according to manufacturer's instructions for one of one	01750			

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01750	Continued From page 54 resident (R5). This had the potential to affect all 33 residents. 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). The findings include: TRAINING/COMPETENCY On February 21, 2024, from 7:00 a.m., to 8:20 a.m., the surveyor observed ULP-D administer residents their scheduled morning medications. During the time of the medication observation, ULP-D was not under direct supervision. On February 21, 2024, at 12:36 p.m., ULP-D stated she was contracted staff by [contracted agency name]. ULP-D stated she had not received medication administration training by the contracted agency. ULP-D stated when she started working for the licensee, ULP-D did not receive medication administration training by the licensee's RN or had to demonstrate competency in medication administration. ULP-D began employment on August 30, 2023, to provide assisted living services to the licensee's residents. ULP-D's employee record lacked evidence ULP-D completed training and demonstrated competency by the RN in medication administration.	01750			

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01750	Continued From page 55 R2's February 2024, Medication Administration Record (MAR) indicated ULP-D administered R2's medications on the following days: February 3, 12, 16, and 21, 2024. R2's MAR indicated ULP-D documented medication errors occurred by ULP-D on February 16, 2024, for R2's scheduled 8:00 a.m., medications. R2's progress note dated February 16, 2024, at 9:17 a.m., indicated R2 was given another resident's medications. R2's medications were held, CNS-B called the pharmacist and R2's BP was to be monitored every four hours. R2's blood pressure report dated February 15, 2024, through February 17, 2024, lacked documentation R2's blood pressure was monitored on February 16, 2024, as directed by CNS-B. On February 21, 2024, at 12:10 p.m., licensed assisted living director (LALD)-A stated agency contracted staff receive a facility tour, are trained on RTasks (electronic medical record system) if needed. LALD-A stated the licensee's RN does not complete medication training or competency evaluations with the agency staff because the staff the agency provided were already trained and ready to go. On February 23, 2024, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated she did not complete a medication incident report for ULP-D medication error for R2. CNS-B stated she didn't think about it at the time of the incident and should have completed an incident report. CNS-B stated she was working the morning R2 received the wrong medications and consulted with R2's pharmacist. CNS-B and R2's pharmacist reviewed the wrong	01750			

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01750	Continued From page 56 medications R2 received, and the pharmacist directed to monitor R2's blood pressure. CNS-B stated she gave verbal instructions for ULP-D to monitor R2's blood pressure every four hours. CNS-B reviewed R2's recorded blood pressures from February 15, 2024, through February 17, 2024, and stated there were no documented blood pressures for R2 on February 16, 2024, the day of the incident as instructed. The licensee's undated Training ULP for Medication, Treatment, and Therapy Administration policy, indicated before the RN delegated the task of assistance with self-administration of medications or the task of medication administration, treatment and therapy, the RN would instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. NO WRITTEN INSTRUCTIONS R5's diagnoses included mild intellectual impairment and reactive airway disease (narrowing of the airway caused by an irritant). R5's Service Plan dated March 23, 2021, indicated R5 received medication management services. R5's prescriber orders dated May 11, 2023, included Symbicort 80-4.5 micrograms (mcg) inhale two puffs twice a day for asthma. On February 21, 2024, at 7:22 a.m., the surveyor observed ULP-E hand R5 her Symbicort inhaler to self-administer. R5 activated the inhaler and immediately inhaled to puffs of the medication. After R5 self-administered her inhaler, ULP-E did not instruct R5 to rinse her mouth after use.	01750			

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01750	Continued From page 57 ULP-E documented inhaler was administered. ULP-E stated R5's electronic record did not include written instructions for R5 to rinse her mouth after the use of the inhaler or did not indicate R5 was able to self-administer her own inhaler. R5's Medication Administration Summary dated February 1 through 23, 2024, indicated R5 received Symbicort 80-4.5 mcg two puffs twice daily; however, lacked specific written instructions for the use of the inhaler to include to rinse mouth after use. On February 23, 2024, at 1:23 p.m., LALD-A stated staff should be administering R5's inhaler because R5 would not know what to do with it. LALD-A stated there were no written directions in R5's record to rinse mouth out after use but can easily add it. The licensee's undated Administration of Medication, Treatment, and Therapy by ULP policy indicated when medication management is delegated to an ULP, the registered nurse (RN) would develop written, specific instructions for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed evaluation supervisor review on February 26, 2024, however non-compliance remains at a scope and level of three, widespread (I).	01750			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication	01760			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 58 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-D administered medications per the manufacturer's instructions for two of two residents (R5, R3) observed during medication administration and failed to administer medications as ordered by prescriber for one of one resident (R2) reviewed for medication errors. 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:	01760			

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01760	Continued From page 59 MEDICATION ADMINISTRATION PER MANUFACTURER INSTRUCTIONS R5 R5's diagnoses included mild intellectual impairment and reactive airway disease (narrowing of the airway caused by an irritant). R5's Service Plan dated March 23, 2021, indicated R5 received medication management services. R5's prescriber orders dated May 11, 2023, included Symbicort 80-4.5 micrograms (mcg) inhale two puffs twice a day for asthma. On February 21, 2024, at 7:22 a.m., the surveyor observed ULP-D hand R5 her Symbicort inhaler to self-administer. R5 activated the inhaler and immediately inhaled to puffs of the medications. After R5 administered her inhaler, ULP-E did not instruct R5 to rinse her mouth after use. R3 R3's diagnoses included diabetes type II, schizophrenia and paranoia with hallucinations. R3's Service Plan dated February 8, 2021, indicated R3 received medication management services. R3's prescriber orders dated March 30, 2023, included an order for Novolog Flexpen (rapid-acting insulin) to inject 0 to 12 units depending on blood glucose (sugar in the blood) three times a day with a meal. On February 21, 2024, at 7:27 a.m., the surveyor observed ULP-D observe R3 check his own blood glucose with his blood glucose meter and ULP-D recorded the results of 197 milligrams per	01760			

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01760	Continued From page 60 deciliter (mg/dl). ULP-D stated R3 would receive three units of Novolog insulin. ULP-D dial the pen to three units, handed the insulin pen to R3 and R3 injected three units of Novolog into his right abdomen area. ULP-D was not observed to prime the insulin pen two units prior to dialing up three units of insulin and handing the insulin pen to R3 to self-administer. On February 21, 2024, at 7:35 a.m., immediately following the above noted observations, ULP-D stated she forgot to prime R3's insulin pen prior to dialing up the prescribed dose. ULP-D stated she was not trained by the licensee or the contracted agency on medication administration and had previous work experience administering medications. On February 21, 2024, at 11:02 a.m., clinical nurse supervisor (CNS)-B stated there were written instructions in RTasks (electronic health record software) to prime insulin pen two units and staff should be following any specific instructions. CNS-B stated she was unsure how ULP-D was trained on inhaler administration because ULP-D was contracted agency staff, and the agency provided all trainings. The manufacturer's Symbicort inhaler dated December 2017, directed to rinse your mouth with water and spit the water out after each dose (2 puffs) of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat. The manufacturer's instructions for Novolog insulin dated December 2015, indicated for the insulin pen to dial the insulin pen to two units and discard prior to dialing up the prescribed dosage.	01760			

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01760	Continued From page 61 MEDICATION ADMINISTRATION ERROR R2 R2's diagnoses included diabetes, chronic kidney disease stage three, depression, epilepsy, and long-term use of insulin. R2's Service Plan dated August 3, 2023, indicated R2 received medication administration assistance eight times a day. R2's Medication Management Plan dated November 22, 2023, indicated staff would administer all medications. R2's Individual Abuse Prevention Plan and Assessment dated November 27, 2023, indicated R2 required assistance with medications and was at risk to be abused (physically, verbally, financially, and/or sexually). R2's progress note dated February 16, 2024, at 9:17 a.m., indicated R2 was given another resident's medications. R2's medications were held, clinical nurse supervisor (CNS)-B called the pharmacist and R2's BP was to be monitored every four hours. R2's blood pressure report dated February 15, 2024, through February 17, 2024, lacked documentation R2's blood pressure was monitored on February 16, 2024, as directed by CNS-B. On February 23, 2024, at 9:54 a.m., CNS-B stated she was working the morning R2 received the wrong medications administered by ULP-D. CNS-B stated she and R2's pharmacist reviewed the wrong medications R2 received, and the pharmacist directed to monitor R2's blood pressure. CNS-B stated she gave verbal	01760			

Minnesota Department of Health

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01760	Continued From page 62 instructions for ULP-D to monitor R2's blood pressure every four hours. CNS-B reviewed R2's recorded blood pressures from February 15, 2024, through February 17, 2024, and stated there were no documented blood pressures for R2 on February 16, 2024, the day of the incident. CNS-B stated she should have completed an incident report at the time the medication error was discovered. The licensee's Administration of Medication, Treatment, and Therapy by ULP policy undated, indicated medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person; b. Right medication, treatment or therapy c. Right time; d. Right route (by mouth, eye drops, to the skin, etc.); e. Right dose (how many milligrams, drops, etc); and f. Right chart/record to document that the medication, treatment and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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.	01890			

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01890	Continued From page 63 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for R2, R6, R7, R8, R11. In addition, the licensee failed to monitor for expired medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TIME SENSITIVE MEDICATIONS On February 20, 2024, at 12:08 p.m., the surveyor observed medication A cart with clinical nurse supervisor (CNS)-B and registered nurse (RN)-C. CNS-B confirmed the following: -R6's opened Spiriva inhaler (used to treat brochospasms) lacked the date the inhaler had been opened and when the inhaler would expire. -R7's opened Novolog flex insulin pen (rapid acting insulin) lacked the date the insulin pen had been opened and when the insulin pen would expire. -R7's opened Lantus Solostar insulin pen (long acting insulin) lacked the date the insulin pen had been opened and when the insulin pen would expire. -R7's opened Humalog Kwik insulin pen (fast acting insulin) lacked the date the insulin pen had been opened and when the insulin pen would expire.	01890			

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01890	Continued From page 64 -R7's opened Victoza injector pen (helps the body make more insulin) lacked the date the infector pen had been opened and when the medication would expire. -R8's two opened Lantus Solostar insulin pens lacked the date the insulin pens had been opened and when the insulin pens would expire. EXPIRED MEDS -R7's opened bottle of GaviLax powder (used to treat constipation) had expired November 2023. On February 20, 2024, at 12:26 p.m., the surveyor observed medication cart B with CNS-B and RN-C. CNS-B confirmed the following: -R2's opened Novolog and Lantus insulin pens lacked the date the insulin pens had been opened and when the insulin pens would expire. EXPIRED MEDICATION -an opened container of stock antacid 500 mg had expired March 2023. On February 20, 2024, at 12:32 p.m., the surveyor observed medication cart C with CNS-B and RN-C. CNS-B confirmed the following: -R11's opened Lantus insulin pen lacked the date the insulin had been opened and when the insulin pen would expire. On February 20, 2024, at 12:38 p.m., CNS-B confirmed time-sensitive medications such as inhalers, eye drops, and insulins, should be dated after opening to include the date the medications would expire. CNS-B stated the pharmacy usually put stickers on time sensitive medications which included an area to write the opened and expiration date. CNS-B stated she usually maintained the medication carts to ensure medications were dated and were not expired.	01890			

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01890	Continued From page 65 CNS-B stated the licensee did not have a formal auditing schedule in place for monitoring the medication carts. The manufacturer's instructions for Spiriva Respimat inhaler revised November 2021, indicated to discard three months after insertion of cartridge, throw away the Spiriva Respimat even if it has not been used. The manufacturer's instructions for Novolog insulin dated December 2015, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Lantus Solostar insulin pen dated June 2022, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Humalog KwikPen dated November 2019, indicated to throw away 28 days after opened, even if it still has insulin in it. The manufacturer's instructions for Victoza dated December 2022, indicated when Victoza is being used, you can keep it for one month at room temperature or in the refrigerator. The manufacturer's Symbicort inhaler dated December 2017, directed to throw Symbicort away when counter reaches "0" or three months after Symbicort is removed from the foil pouch. The licensee's Storage of Medication policy dated January 2017, indicated medication must be kept in its original container bearing the original prescription label with legible information stating expiration of time-dated medication.	01890			

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01890	Continued From page 66 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for three of three residents (R1, R2, R3) who received blood glucose monitoring by the facility.	01950			

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01950	Continued From page 67 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: R1 R1's diagnosis included diabetes type II (high levels of sugar in the blood). R1's Service Plan dated February 1, 2024, indicated R1 received blood glucose monitoring four times a day. R2 R2's diagnosis included diabetes type II. R2's Service Plan dated August 3, 2023, indicated R2 received blood glucose monitoring four times a day. On February 21, 2024, at 7:13 a.m., the surveyor observed ULP-E observe R2 scan her FreeStyle Libre device (a device that measures glucose levels through a small sensor applied to the back of the arm) and report a blood glucose result of 74 milligrams per deciliter (mg/dl). ULP stated she was not going to administer R2's insulin until after R2 ate breakfast because R2's blood glucose reading was low. ULP-E reviewed R2's medical record and stated there were no set blood glucose parameters of when to notify the nurse, only to offer a snack if R2's blood glucose level was below 70 mg/dl and to recheck R2's	01950			

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01950	Continued From page 68 blood glucose. R3 R3's diagnoses included diabetes type II. R3's Service Plan dated February 8, 2021, indicated R3 received blood glucose monitoring five times a day. On February 21, 2024, at 7:27 a.m., the surveyor observed ULP-D observe R3 check his own blood glucose with his blood glucose meter and ULP-D recorded the results of 197 mg/dl. ULP-D reviewed R3's medical record in RTasks (electronic documentation record) and stated R3's blood glucose parameters were to offer a snack if R3's blood glucose was below 70 mg/dl and recheck the blood glucose. ULP-D stated there were no set blood parameters in R3's record of what would be considered a low or high blood glucose and when to notify a nurse. R1, R2, and R3's record did not include written blood glucose parameters of when to notify the registered nurse. On February 21, 2024, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated blood glucose parameters for each resident indicated if a blood glucose reading was below 70 mg/dl, offer a snack and recheck the blood glucose in 15 minutes. CNS-B stated there were no set blood glucose parameters in place of when to notify the nurse of an out of range blood glucose. The licensee's undated Administration of Medication, Treatment, and Therapy by ULP policy indicated prior to providing delegated medication administration and or treatment/therapy, the following must occur:	01950			

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01950	Continued From page 69 -the RN would develop written, specific instructions for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			

Type: Full
Date: 02/20/24
Time: 10:30:00
Report: 8010241031

Food and Beverage Establishment Inspection Report

Page 1

Location:

Wesley Residence of Duluth, In
5601 Grand Avenue
Duluth, MN55801
St. Louis County, 69

Establishment Info:

ID #: 0021640
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Wesley Residence of Duluth, In

Phone #: 2186282307
ID #: 34877

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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MILK /JUICE WERE STORED ON ICE IN THE DINING AREA. MAINTAIN FOODS UNDER MECHANICAL REFRIGERATION FOR TEMPERATURE CONTROL BEFORE SERVING. FOODS WERE RETURNED TO COOLERS AT THE TIME OF INSPECTION. SEE COMMENTS.

Corrected on Site

7-200 Toxic Supplies and Applications

7-204.11 **** Priority 1 ****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE CHLORINE CONCENTRATION OF THE WIPING CLOTH BUCKET WAS GREATER THAN THE MAXIMUM OF 200 PPM. THE WIPING CLOTH BUCKET WAS REMADE TO A CONCENTRATION OF 100 PPM.

CHLORINE CONCENTRATION IS BETWEEN 50-200 PPM.

Corrected on Site

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

SNACK ROOM-THERE WERE BOXES OF POTATO CHIPS, PAPER TOWELS AND SINGLE

Type: Full
Date: 02/20/24
Time: 10:30:00
Report: 8010241031
Wesley Residence of Duluth, In

Food and Beverage Establishment Inspection Report

Page 2

SERVICE ITEMS (FOAM CUPS) STORED ON THE FLOOR. STORE ALL ITEMS AT LEAST 6 INCHES ABOVE THE FLOOR.

Comply By: 03/01/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE FREEZERS IN THE STORAGE UNIT ARE TO BE DEFROSTED TO MAINTAIN PROPER AIR CIRCULATION TEMPERATURES AND CLEANABILILTY. (OBSERVED BY NURSE INSPECTOR)

Comply By: 03/01/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

THERE WERE NO HANDWASHING SIGNS IN THE EMPLOYEE RESTROOMS.

Comply By: 03/01/24

Surface and Equipment Sanitizers

Chlorine: > 200 PPM at Degrees Fahrenheit

Location: WIPING CLOTH BUCKET

Violation Issued: Yes

Chlorine: = 100 PPM at Degrees Fahrenheit

Location: WIPING CLOTH BUCKET-REMADE

Violation Issued: No

Chlorine: = 50 PPM at Degrees Fahrenheit

Location: DISHWASHER SANITIZING CYCLE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding

Temperature: 202 Degrees Fahrenheit - Location: LASAGNA-OVEN

Violation Issued: No

Process/Item: Hot Holding

Temperature: 197 Degrees Fahrenheit - Location: GREEN BEANS-STOVETOP

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 39 Degrees Fahrenheit - Location: PREPACKAGED BOILED EGGS-KITCHEN

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 37 Degrees Fahrenheit - Location: HAM SALAD-KITCHEN

Violation Issued: No

Type: Full
Date: 02/20/24
Time: 10:30:00
Report: 8010241031
Wesley Residence of Duluth, In

Food and Beverage Establishment
Inspection Report

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: SLICED TOMATOES-KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: RAW CHICKEN-COMMERCIAL
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: MILK-TURBO AIR
Violation Issued: No

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

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

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-STORAGE AREA
Violation Issued: No

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

COMMENTS:

DISCUSSED WITH STAFF THAT MILK AND JUICE CAN BE DISTRIBUTED IN GLASSES, KEPT UNDER MECHANICAL REFRIGERATION AND INDIVIDUALLY SERVED FROM THE REFRIGERATOR WHEN NEEDED.

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

FAIR MEADOW WHOLE EGGS WITH CITRIC ACID IS A PASTEURIZED PRODUCT.

Type: Full
Date: 02/20/24
Time: 10:30:00
Report: 8010241031
Wesley Residence of Duluth, In

Food and Beverage Establishment Inspection Report

Page 4

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 8010241031 of 02/20/24.

Certified Food Protection Manager Nancy L. Hillstrom

Certification Number: FM94247 Expires: 05/31/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sharon Olson

Signed: 
8010

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

Report #: 8010241031		Food Establishment Inspection Report							
 Minnesota Department of Health Minnesota Department of Health PO Box 64975 St. Paul, MN 55164-0975		No. of RF/PHI Categories Out		2		Date 02/20/24			
		No. of Repeat RF/PHI Categories Out		0		Time In 10:30:00			
		Legal Authority MN Rules Chapter 4626				Time Out			
Wesley Residence of Duluth, In		Address 5601 Grand Avenue		City/State Duluth, MN		Zip Code 55801		Telephone 2186282307	
License/Permit # 0021640		Permit Holder Wesley Residence of Duluth, In		Purpose of Inspection Full		Est Type		Risk Category H	
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 Hygienic 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					
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 ☐ IN ☐ OUT				Water & ice obtained from an approved source					
32 IN ☐ OUT ☒ N/A				Variance obtained for specialized processing methods					
Food Temperature Control									
33 ☐ IN ☐ OUT				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 ☐ IN ☐ OUT				Thermometers provided & accurate					
Food Identification									
37 ☐ IN ☐ OUT				Food properly labeled; original container					
Prevention of Food Contamination									
38 ☐ IN ☐ OUT				Insects, rodents, & animals not present					
39 X ☐ IN ☐ OUT				Contamination prevented during food prep, storage & display					
40 ☐ IN ☐ OUT				Personal cleanliness					
41 ☐ IN ☐ OUT				Wiping cloths: properly used & stored					
42 ☐ IN ☐ OUT				Washing fruits & vegetables					
Food Recalls:									
Person in Charge (Signature)									
Date: 02/21/24									
Inspector (Signature) 									