Electronically Delivered

October 25, 2022

Administrator
Goldpine Home
1700 30th Street Northwest
Bemidji, MN 56601

RE: Project Number(s) SL30332015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 5, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that

consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30332 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDPINE HOME | 1700 30TH STREET NW BEMIDJI, MN 56601 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL30332015<br><br>On, October 3, 2022, through October 5, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 68 residents; with 64 residents receiving services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and post a written staffing plan. This had the potential to affect all residents.<br><br>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 | 0 470 | | |

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| 0 470 | Continued From page 2<br>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee held an assisted living license. The facility was licensed for a capacity of 97 residents and had a current census of 68 residents.<br><br>During the entrance conference on October 3, 2022, at 10:00 a.m., registered nurse (RN)-A stated the usual staffing schedule for the facility was as follows:<br>- RN on call 27/4, call was shared between two RN's; each were on call for one week at a time before "hand-off" occurred.<br>- RN-A was on site Monday through Friday from 7:00 a.m. until 3:30 p.m. or 4:00 p.m., adding that [schedule] would be ideal.<br>- the first shift/day shift: varied, first staff arrived at 6:00 a.m. until 2:00 p.m., or 6:00 p.m., and consisted of 4-5 staff: certified nursing assistances (CNA), licensed practical nurses (LPN), or med aid, and RN.<br>- the second shift/afternoon shift: started at 2:00 p.m. until 10:00 p.m. and consisted of 4-5 staff.<br>- the third shift/night shift: varied, started at 6:00 p.m. until 6: 00 a.m. or 10:00 p.m. until 6:00 a.m., and consisted of 1 LPN, 2 CNAs and sometimes a third.<br>RN-A added, "A few 5:00 p.m. until 10:00 pm. shifts for students, and 2 staff that have kids so they start at 6:30 a.m."<br><br>On October 3, 2022, at 11:19 a.m., during a facility tour with RN-A it was observed that the facility did not have a staffing plan posted. RN-A verified the staffing plan was not posted, "it is here, on clip board" in the nurse's station. | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>On October 3, 2022, at 1:25 p.m., the surveyor asked to see the facility's staffing plan. The surveyor was provided a form dated May 10, 2022, with "Staffing Plan" handwritten on the top of the paper that included bonuses, hazard pay, and "other ways we [facility] will supplement if needed" numbered 1-7 with options for staffing. RN-A stated with every admission she reviews staffing, in her head. RN-A confirmed she had not developed a written staffing plan for the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced | 0 480 | | |

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| 0 480 | Continued From page 4<br>by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>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).<br>The findings include:<br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 3, 2022, for the specific Minnesota Food Code deficiencies.<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(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;<br>(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; | 0 490 | | |

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| 0 490 | Continued From page 5<br>(vi) provide culturally sensitive programs; and<br>(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<br><br>This MN Requirement is not met as evidenced by:<br>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 64 residents who were being provided services at the facility.<br><br>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).<br><br>Findings include:<br><br>During the entrance conference on October 3, 2022, at 10:05 a.m., the surveyor asked if the facility had a daily activity calendar. Registered nurse (RN)-A stated the monthly activity calendar was posted throughout the building in common areas. RN-A stated activity director (AD)-C oversaw the facility's activity program.<br><br>On October 3, 2022, at 11:03 a.m., the surveyor | 0 490 | | |

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| 0 490 | Continued From page 6<br><br>toured the facility with RN-A. The October 2022, activity calendar was posted on the side of a wooden cabinet in the dining room area. The calendar included at least one scheduled activity except for Sunday October 2, 16, 23, and 30th. The date boxes for these dates were left blank.<br><br>On October 3, 2022, at 1:55 p.m., the surveyor asked AD-C for a copy of the facility's September activity calendar. The October and September activity calendars were provided and reviewed with AD-C. The September 2022 activity calendar was noted to include at least one scheduled activity except for Sunday September 4, 11, 18, and 25th. AD-C stated they do not routinely have an activity scheduled or planned for Sundays. AD-C stated they do have an activity person here on Sundays, but they primarily assist the residents at mealtime.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 490 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and | 0 640 | | |

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| 0 640 | Continued From page 7<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 68 residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at approximately 10:50 a.m., during the facility tour, the surveyor did not obverse 911 posted on or near telephones in the commons area as required.<br><br>On October 3, 2022, at 11:16 a.m., licensed assisted living director (LALD)-B verified the 911 emergency number was not posted at or near telephones or in the commons area in the west wing, at the life enrichment desk, or in the south wing of the facility. LALD-B verified she was not aware 911 was posted near any of the telephone at the facility<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One | 0 640 | | |

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| 0 640 | Continued From page 8<br>(21) days | 0 640 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. | 0 680 | | |

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| 0 680 | Continued From page 9<br><br>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).<br><br>During the entrance conference on October 3, 2022, at 10:37 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided to and later reviewed by the surveyor.<br><br>The licensee's EPP plan provided to the surveyor included in the front of the binder, two one-page documents which provided direction for the staff to follow in the case of severe weather alerts: tornado, and a "quick reference" for fire, updated date May 8, 2014. The binder also included some information with effective date of January 1, 2013. The licensee's EPP lacked the following:<br>- a completed risk assessment;<br>- a comprehensive program to include infectious diseases and pandemics;<br>- policies and procedures to address natural and man-made disasters<br>- a description of the facilities approach to meeting the health/safety/security needs of the staff and residents (binder included agreements with pharmacies, effective date January 1, 2013);<br>- process for EP cooperation with state and local EP officials/organizations;<br>- a missing resident plan that was reviewed quarterly (policy dated January 3, 2002);<br>- arrangements/contracts to re-establish utility services);<br>- a description of the population served by the | 0 680 | | |

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| 0 680 | Continued From page 10<br>licensee;<br>- development of policies/procedures to address:<br>- procedure for tracking staff and residents;<br>- subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems);<br>- evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated;<br>- shelter in place;<br>- a medical record documentation system to preserve resident information, security, and availability;<br>- emergency staffing strategies to include volunteers;<br>- development of arrangements with other facilities and providers to receive residents if needed; and<br>- the facilities role in providing care and treatment at alternative sites under a 1135 waiver, (agreement in binder with effective date January 1, 2013);<br>- a communication plan that included:<br>- arrangement with other facilities (agreements in binder with effective date January 1, 2013);<br>- names and contact information for staff, resident physicians, other facilities, volunteers;<br>- contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies;<br>- primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies;<br>- a method of sharing information and medical documentation for residents; | 0 680 | | |

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| | 30332 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

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| GOLDPINE HOME | 1700 30TH STREET NW BEMIDJI, MN 56601 |

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| 0 680 | Continued From page 11<br><br>- a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and<br>- a method of sharing information from the EPP with residents and their families.<br><br>On October 3, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-B stated there was an EPP binder in the nurse's station, behind a locked door, adding there were seven (7) EPP binders in total throughout the facility. LALD-B added she thought there maybe one at the life enrichment desk that was not behind a locked door, however an EPP binder was not found at that location.<br><br>On October 3, 2022, at 12:13 p.m., the surveyor reviewed the EPP binder with registered nurse (RN)-A. RN-A verified the facility's emergency preparedness plan/program had not been fully developed as required. RN-A added she thought what happened was we [facility] knew it [EPP] had been done at one time.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |
| 01370 SS=F | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following:<br>(1) documentation requirements for all services provided;<br>(2) reports of changes in the resident's condition | 01370 | | |

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| 01370 | Continued From page 12<br>to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(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;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-I) to include all | 01370 | | |

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| 01370 | Continued From page 13<br>required content.<br><br>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).<br><br>The findings include:<br><br>ULP-I was hired on May 25, 2022, to provide direct care to residents at the assisted living facility.<br><br>On October 3, 2022, at 1:10 p.m., the surveyor observed ULP-I and ULP-M to transfer R18 from the recliner to the bed using a Hoyer lift (a mechanical lifting/transferring device) and provide incontinence cares.<br><br>ULP-I's employee record did not include documentation of training and competency evaluations for the following topics:<br>- documentation requirements for all services provided<br>- reports of changes in the resident's condition to the supervisor designated by the facility<br>- care and use of hearing aides<br>- training on the prevention of falls<br>- medication, exercise, and treatment reminders<br>- basic nutrition, meal preparation, food safety, and assistance with eating, and<br>- preparation of modified diets as ordered by a licensed health professional<br><br>On October 5, 2022, at 11:55 a.m., registered nurse (RN)-A stated ULP-I had not received the | 01370 | | |

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| 01370 | Continued From page 14<br>above required training and competency evaluations. RN-A stated we are going to have to add these topics to our orientation.<br><br>The required policy and procedure was requested, however, not provided.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01370 | | |
| 01380 SS=F | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-I) to include all | 01380 | | |

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| 01380 | Continued From page 15<br>required content.<br><br>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).<br><br>The findings include:<br><br>ULP-I was hired on May 25, 2022, to provide direct care to residents at the assisted living facility.<br><br>On October 3, 2022, at 1:10 p.m., the surveyor observed ULP-I and ULP-M to transfer R18 from the recliner to the bed using a Hoyer lift (a mechanical lifting/transferring device) and provide incontinence cares.<br><br>ULP-I's employee record did not include documentation of training and competency evaluations for the following topics:<br>- observing, reporting, and documenting resident status<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident, and<br>- range of motion and positioning<br><br>On October 5, 2022, at 11:55 a.m., registered nurse (RN)-A stated ULP-I had not received the above required training and competency evaluations. RN-A stated we are going to have to | 01380 | | |

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| 01380 | Continued From page 16<br>add these topics to our orientation.<br><br>The required policy and procedure was requested, however, not provided.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01380 | | |
| 01470 SS=F | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and | 01470 | | |

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| 01470 | Continued From page 17<br><br>Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for three of three employees (unlicensed personnel (ULP)-E, ULP-I, licensed practical nurse (LPN)-G,).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01470 | | |

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| 01470 | Continued From page 18 | 01470 | | |

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:

ULP-E
ULP-E was hired on October 30, 2020, to provide direct care to residents at the assisted living facility.

On October 3, 2022, at 2:12 p.m., the surveyor observed ULP-E and ULP- L to transfer R4 from his wheelchair to the bed using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) and provide incontinence cares.

ULP-E's employee record lacked the following required orientation content:
- an overview of the 144 G statutes, and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure

ULP-I
ULP-I was hired on May 25, 2022, to provide direct care to residents at the assisted living facility.

On October 3, 2022, at 1:10 p.m., the surveyor observed ULP-I and ULP-M to transfer R18 from the recliner to the bed using a Hoyer lift (a mechanical lifting/transferring device) and provide incontinence cares.

ULP-I's employee record lacked the following

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| 01470 | Continued From page 19<br>required orientation content:<br>- an overview of the 144 G statutes, and<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure<br><br>LPN-G<br>LPN-G was hired on September 21, 2022, to provide direct care to residents at the assisted living facility.<br><br>On October 4, 2022, at 7:25 a.m., the surveyor observed LPN-G remove R16's Fosamax 70 mg tablet from the medication cart in the nurse's station, put the medication into a medication cup and take medication to R16's room. LPN-G gave the medication cup to R16 and handed her a container of water which was on a table near R16's bedside.<br><br>LPN-G's employee record lacked the following required orientation content:<br>- an overview of the 144 G statutes,<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and<br>-the principles of person-centered planning and service delivery and how they apply to direct support services proved by the staff person.<br><br>On October 5, 2022, at 10:39 a.m., registered nurse (RN)-A stated the above noted assisted living orientation had not been completed for ULP-E, ULP-I or LPN-G. RN-A stated they will need to update their assisted living orientation.<br><br>The required policy and procedure was requested, however, not provided. | 01470 | | |

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| 01470 | Continued From page 20<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |
| 01530 SS=D | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.<br>Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of two | 01530 | | |

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| 01530 | Continued From page 21<br>employees (unlicensed personnel (ULP)-I) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>ULP-I was hired on May 25, 2022, to provide direct care to residents at the assisted living facility.<br><br>On October 3, 2022, at 1:10 p.m., the surveyor observed ULP-I and ULP-M to transfer R18 from the recliner to the bed using a Hoyer lift (a mechanical lifting/transferring device) and provide incontinence cares.<br><br>ULP-I's employee record did not indicate a total of eight hours of the required dementia training was completed within 160 hours of the employee's start date. ULP-I's employee record indicated the employee had completed 5.75 hours of dementia training.<br><br>On October 5, 2022, at 10:40 a.m., registered nurse (RN)-A reviewed ULP-I's education records and stated ULP-I had not completed all the dementia training that was required and confirmed ULP-I was short 2.25 hours.<br><br>The required policy and procedure was requested, however, not developed. | 01530 | | |

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| 01530 | Continued From page 22<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01530 | | |
| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were administered per manufacturer's instructions for two of two residents (R9, R16) who received medication management services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has | 01760 | | |

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| 01760 | Continued From page 23<br>occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R9<br>R9's diagnoses included diabetes, hypertension (HTN-high blood pressure), congested heart failure (a condition in which the heart's function as a pump is inadequate to meet the body's needs), and cerebral vascular accident (CVA-stroke).<br><br>R9's prescriber orders dated August 29, 2022, included an order for Basaglar insulin eight units to be administered once daily.<br><br>R9's service plan dated June 4, 2021, indicated the resident received medication management services to include medication administration. R9's Assessment dated August 10, 2022, indicated R9 received assistance with insulin administration.<br><br>On October 4, 2022, at 7:50 a.m., the surveyor observed licensed practical nurse (LPN)-G to prepare R9's scheduled Basaglar insulin. LPN-G removed from the locked medication cart R9's Basaglar insulin pen (a multiple dose pen shaped injector device for insulin administration). The surveyor observed LPN-G to remove the insulin pen cap and to wipe the rubber seal with an alcohol wipe. LPN-G then proceeded to take an insulin syringe, remove the syringe cap, and pierce the rubber seal of the insulin pen with the needle of the insulin syringe. LPN-G then drew up eight units of insulin from the Basaglar insulin pen into the insulin syringe.The surveyor asked LPN-G who had taught her to prepare insulin in this manner and LPN-G responded the registered nurse (RN) at the facility had instructed them to | 01760 | | |

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| 01760 | Continued From page 24 | 01760 | | |

draw up the insulin from the insulin pen into an insulin syringe. LPN-G stated, "I had never seen it be done like this before" and was just doing what they had "told her to do". LPN-G then proceeded to R9's room and administered R9's scheduled eight units of Basaglar insulin.

On October 5, 2022, at 10:49 a.m., RN-A stated the staff have been trained to draw up the insulin from the insulin pens into an insulin syringe as it is sometimes hard to get the capped needles for the insulin pens. RN-A stated the pharmacist had told them this was okay. RN-A stated she should have maybe looked this up to make sure this was an okay practice.

On October 5, 2022, at 12:01 p.m., RN-A stated she had spoken to the pharmacist and the pharmacist stated they would be switching to insulin vials going forward as drawing up from an insulin pen was an outdated practice and has the potential for administering incorrect doses.

The manufacturer's instructions for the use of Basaglar insulin pens, dated 2021, included the following instructions for preparing the insulin pen for administration:
- pull the pen cap straight off the pen
- wipe the rubber seal with an alcohol swab
- check the liquid in the pen
- select a new needle and push the capped needle straight onto the pen
- prime the pen
- dial up the selected dosage of insulin; and
- administer the correct dose of insulin

The licensee's Use of the Disposable Insulin Deliver Device (Insulin Pen) dated January 3, 2002, included the following procedure for preparing the insulin pen for administration:

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| 01760 | Continued From page 25<br>- check the label on the pen to be sure it contains the type of insulin that was prescribed by the physician<br>- remove pen cap<br>- use an alcohol swab to wipe the rubber seal on the end of the pen<br>- attach the capped needle to the end of the pen<br>- remove the outer cap shield and prime the insulin pen with two units<br>- dial the correct dose<br>- administer the insulin<br><br>The Primary Care Diabetes Society resource dated February 28, 2015, noted transferring insulin from a pen cartridge or prefilled pen to an insulin syringe is NOT a practice that is endorsed by any of the insulin manufacturers and is an unlicensed activity. Drawing insulin out of a prefilled pen or cartridge cannot be recommended. Risks include dosing errors, which can lead to significant harm should this result in overdose of insulin.<br><br>R16<br>R16's diagnoses included HTN, systemic inflammatory response syndrome (SIRS-serious condition in which there is inflammation throughout the whole body), reactive airway disease that is not asthma, arthritis, and memory impairment/ gradual onset.<br><br>R16's prescriber orders dated May 16, 2022, included Fosamax [used in the treatment of osteoporosis, decreases the rate bone calls are absorbed, reducing absorption allowing the body to increase bone density, reducing the risk of | 01760 | | |

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fracture] 70 milligrams (mg) take 1 tab by mouth 1 time (x)/week. Take ½ hour before first food of the day. Do not lie down for 30 minutes (min) after taking.

R16's service plan dated September 20, 2022, indicated the resident received medication management services to include medication administration 1 day a week, and mediation administration 4 times per day, daily.

R16's Assessment dated May 22, 2022, indicated R16 needed full medication management and setup, and administration per doctor's orders as described in medication administration record (MAR).

R16's MARs dated September 1, 2022, through October 4, 2022, included Fosamax, take 1 tab by mouth 1x/week on Tuesday. Take ½ hour before first food of the day. Do not lie down for 30 minutes after taking.

On October 4, 2022, at 7:25 a.m., the surveyor observed LPN-G remove R16's Fosamax 70 mg tablet from the medication cart in the nurse's station, put the medication into a medication cup and take the medication to R16's room. R16 was lying in bed with a blanket covering her chest. LPN-G gave the medication cup to R16 and handed her a container of water which was on a table near R16's bedside. R16 took a sip or two of the water and handed the container back to LPN-G. LPN-G told R16 she would be back later with her morning medications as LPN-G exited R16's room. The surveyor did not observe LPN-G to instruct R16 to sit up or stand up and not to eat or drink anything for the next 30 minutes.

On October 4, 2022, directly following the above

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| 01760 | Continued From page 27<br>observation, LPN-G confirmed no instructions regarding Fosamax had been given to R16. LPN-G added, R16 is "usually sitting in her chair when I go in there, I was not use to her in bed."<br><br>On October 5, 2022, at 10:30 a.m., RN-A verified the instructions documented in the MAR were to be followed, "a glass of water and up in chair".<br><br>The manufacturer's instructions for Fosamax, dated February 1, 2022, included:<br>- you must take Fosamax exactly as directed to help make sure it works and to help lower the chance of harmful side effects<br>- after getting up for the day and before taking your first food, drink, or other medication, swallow your Fosamax tablet with a full glass (6-8 ounces) of plain water only<br>- do not chew or such on a tablet of Fosamax<br>- after swallowing your Fosamax tablet, wait at least 30 minutes before taking your first food, drink, or other medication of the day. Fosamax is effective only if it is taken when our stomach is empty, and<br>- do not take Fosamax at bedtime or before getting up for the day.<br><br>The licensee's Medication Management Services policy reviewed April 30, 2021, indicated staff was to administer the medications as prescribed and document the administration appropriately with authentication by each staff person by discipline or title.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |

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| 01810 | Continued From page 28 | 01810 | | |
| 01810 SS=E | 144G.71 Subd. 12 Medications; over-the-counter drugs; dietary<br><br>An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure over-the-counter (OTC) drugs were stored as appropriate for two of five resident (R3, R16).<br><br>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).<br><br>The findings include:<br><br>R3<br>On October 3, 2022, at 1:05 p.m., the surveyor observed an opened plastic bottle of antiseptic skin cleanser, prescription number (Rx) 6115092 in the west wing shower room, sitting on a shelf with OTC shampoo products. Administrator (A)-D stated he had nothing to do with showers, but added he "thought it [prescribed skin cleanser] | 01810 | | |

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| 01810 | Continued From page 29<br>should be secured." A-D directed the surveyor to registered nurse (RN)-A regarding the prescribed skin cleanse.<br><br>On October 3, 2022, at 1:09 p.m., RN-A verified all prescriber's ordered medications should be in a locked medication cart. RN-A asked A-D to put the prescribed skin cleanse in a medication cart.<br><br>R16<br>On October 4, 2022, at 7:25 a.m., the surveyor observed licensed practical nurse (LPN)-G enter R16's room to administer R16's 7:00 a.m., morning medication. On a side table in R16's room was an opened container of Anti Monkey Butt container.<br><br>On October 5, 2022, at 10:34 a.m., RN-A verified OTCs are to be stored in the locked medication cart, in the lower bin if it [medication] is to big to fit in the drawer.<br><br>The licensee's Self-Administration of OTC Drugs Self-Administration with home health aide (HHA)/LPN/RN Observation of Medication policy reviewed July 1, 2002, indicated;<br>- medication will be kept in a locked drawer or cabinet in the resident's room. Resident would be responsible for the key. Staff will keep a labeled back-up key in narcotic cupboard; and<br>- if medications are stored by staff, the HHA/LPN/RN will bring them to the resident to monitor set-up and self-administration.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01810 | | |

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| 01880 | Continued From page 30 | 01880 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations.<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at 10:50 a.m., the surveyor toured the facility with registered nurse (RN)-A, including a review of the medication refrigerators on the north and west wings. RN-A visualized and stated the current temperature for these two medication refrigerators was 37 degrees Fahrenheit (F). RN-A stated the medication refrigerator temperatures were monitored and recorded daily in their electronic record by the night staff. The surveyor asked for the medication refrigerator logs for September and October 2022. | 01880 | | |

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| 01880 | Continued From page 31<br><br>On October 3, 2022, at 11:55 a.m., the medication refrigerator temperature logs dated September 3, 2022, through October 2, 2022, were provided and reviewed with RN-A. This report included daily temperature readings of the three medication refrigerators (north, south, and west). Ten out of the 90 opportunities the temperature was recorded as being out of the acceptable range (36 to 46 degrees F). The out-of-range temperatures were recorded as being 34 or 35 degrees F. RN-A stated when the temperatures are out of range of the parameters the staff should adjust the temperature to get it back within the acceptable range and this was not being done.<br><br>On October 3, 2022, at 12:05 p.m., the surveyor and RN-A completed a general inventory of the north, south, and west medication refrigerators. The medication refrigerators included the following medications (not an inclusive list):<br>- R6's unopened vials of Lantus and Novolog 100 units/milliliter (ml) insulin<br>- R7's three (3) unopened bottles of Latanoprost 0.005% eye drop solution (glaucoma medication) and two (2) vials of Lantus 100 units/ml insulin<br>- R8's unopened bottle of Latanoprost 0.005% eye drop solution<br>- R10's unopened box of Basalgar 100 units/ml insulin pens<br>- R15's unopened bottle of Latanoprost 0.005% eye drop solution<br><br>The manufacturer's instructions for Lantus insulin dated December 2019 indicated before opening store the insulin in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze.<br><br>The manufacturer's instructions for Novolog | 01880 | | |

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| 01880 | Continued From page 32<br>dated June 2021 indicated before opening store the insulin in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze.<br><br>The manufacturer's instructions for Latanoprost dated June 2014, indicated to store unopened bottles in the refrigeration at 36-46 degrees F.<br><br>The manufacturer's instructions for Basaglar insulin pens dated July 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Basaglar to freeze.<br><br>The licensee's undated Pharmacy Policies noted both nurses and pharmacists shared the responsibility for the care of the drugs at the nursing stations. All the drugs at the nursing and treatment stations will be inspected at least monthly by the nursing unit supervisor and monthly by the Consultant Pharmacist. During the inspections, the responsible person will check for drugs that are improperly stored.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>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 33<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for four of four residents (R7, R11, R12, R13) and failed to monitor for expired medications for three of three residents (R5, R14, R15).<br><br>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).<br><br>The findings include:<br><br>On October 3, 2022, at 10:50 a.m., the surveyor toured the facility with registered nurse (RN)-A, including a review of the locked medication carts on the west and north wing. RN-A observed and confirmed the following:<br><br>ORIGINAL PRESCRIPTION LABEL<br>R7<br>R7's fluticasone propionate and salmeterol 500/50 micrograms (mcg) inhaler and latanoprost 0.005% ophthalmic solution (glaucoma medication) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued.<br><br>R12's Breo Ellipta (corticosteroid inhaler) 100/25 | 01890 | | |

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| 01890 | Continued From page 34<br>mcg inhaler lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued.<br><br>R13<br>R13's Lumigan ophthalmic solution 2.5 milliliters (ml) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued.<br><br>TIME SENSATIVE MEDICATIONS<br>R7's fluticasone propionate and salmeterol 500/50 mcg inhaler and latanoprost 0.005% ophthalmic solution did not have a label which indicated the date the inhaler had been removed from the foil pouch or the date the bottle of latanoprost had been opened and when the inhaler and bottle of solution would expire.<br><br>R11<br>R11's latanoprost 0.005% ophthalmic solution did not have a label which indicated the date the bottle had been opened and when the bottle of solution would expire.<br><br>R12's Breo Ellipta 100/25 mcg inhaler did not have a label which indicated the date the inhaler had been removed from the foil pouch and when the inhaler would expire.<br><br>EXPIRED MEDICATION<br>The following medications were found to be expired:<br>- R5's Systane eye drop solution (to treat dry eyes) expired August 2021<br>- R14's bottle of ibuprofen 200 mg (pain reliever) | 01890 | | |

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| 01890 | Continued From page 35<br>expired March 2022<br>- R15's bottle of MagSRT (supplement) expired August 2021<br><br>On October 3, 2022, at 11:15 a.m., RN-A stated all medications should have an original label, time sensitive medications should be labeled with a date they were opened, and expired medications should be removed from the carts and destroyed. RN-A stated the night shift staff are responsible for checking the medication carts for expired medications and making sure the medications are labeled and dated appropriately.<br><br>The manufacturer's instructions for fluticasone propionate and salmeterol 500/50 mcg inhaler dated August 2020, directed to discard the inhaler one month after opening the foil pouch.<br><br>The manufacturer's instructions for the use of latanoprost eye drop solution dated June 2014, directed for the eye drop solution to be discarded six weeks after it had been opened.<br><br>The manufacturer's instructions for the use of the Breo Ellipta inhaler dated March 2020, directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. The tray opened and discard dates should be written on the inhaler label.<br><br>The licensee's undated Pharmacy Policies noted both nurses and pharmacists shared the responsibility for the care of the drugs at the nursing stations. All the drugs at the nursing and treatment stations will be inspected at least monthly by the nursing unit supervisor and monthly by the Consultant Pharmacist. During the inspections, the responsible person will check for expired drugs, improper labeling and drugs | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30332 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDPINE HOME | 1700 30TH STREET NW BEMIDJI, MN 56601 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 36<br>improperly stored. All drugs that appear to have deteriorated, exceed expiration date, are improperly labeled or not being used are to be returned to the Director of Nursing.<br><br>The licensee's General Policies in Administering Medications dated February 20, 2019, noted medications 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.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01930 SS=F | 144G.72 Subd. 2 Policies and procedures<br><br>(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.<br>(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber | 01930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30332 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDPINE HOME | 1700 30TH STREET NW BEMIDJI, MN 56601 |

| (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 |
|---|---|---|---|---|
| 01930 | Continued From page 37<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on October 3, 2022, at 10:25 a.m., registered nurse (RN)-A stated the licensee provided treatment and therapy services to residents as prescribed.<br><br>On October 3, 2022, at 10:35 a.m., the surveyor asked RN-A and licensed assisted living director (LALD)-B for the licensee's assisted living licensing policies and procedures. The policies and procedures provided did not include treatment and therapy policies to address the following:<br>- requesting and receiving orders or prescriptions for treatments or therapies<br>- providing the treatment or therapy<br>- documenting treatment or therapy activities<br>- educating and communicating with residents | 01930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30332 | A. BUILDING: _____ B. WING _____ | 10/05/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDPINE HOME | 1700 30TH STREET NW BEMIDJI, MN 56601 |

| (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 |
|---|---|---|---|---|
| 01930 | Continued From page 38<br>about treatments or therapies they are receiving<br>- monitoring and evaluating the treatment or therapy, and<br>- communicating with the prescriber<br><br>On October 5, 2022, at 11:50 a.m., RN-A stated the above noted treatment and therapy policies had not been developed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01930 | | |

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Full
Date: *10/03/22*
Time: 12:32:37
Report: 8046221143

# Food and Beverage Establishment Inspection Report



**Location:**
Goldpine Home
1700 30th Street Nw
Bemidji, MN56601
Beltrami County, 04

**Establishment Info:**
ID #: 0038632
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2184444346
ID #:

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

The following orders were issued during this inspection.

**3-500B 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.

OBSERVED TWO DOOR IN OFFICE, AND BULK MILK TO BE 43 AND 44 DEGREES. UNITS WILL BE ADJUSTED OR SERVICED AS NEEDED.

*Comply By: 10/03/22*

**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.

OBSERVED GASKETS BROKEN ON 2-DOOR IN OFFICE. WILL BE ORDERED AND REPLACED.

*Comply By: 12/01/22*

**4-500 Equipment Maintenance and Operation**

4-502.13MN

MN Rule 4626.0833 Cut bulk milk dispensing tubes on the diagonal, leaving no more than one inch protruding from the chilled dispensing head.

OBSERVED MILK IN IMPROPERLY CUT MILK TUBE. TUBE WILL BE CUT CORRECTLY TO ALLOW MILK TO FULLY DRAIN WHEN FILLING.

*Comply By: 10/03/22*

**Surface and Equipment Sanitizers**

Chlorine: = 50 at  Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Chlorine: = 100 at  Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200 at  Degrees Fahrenheit
Location: QUAT DISP
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit  - Location: TWO DOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit  - Location: TWO DOOR OFFICE
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 44 Degrees Fahrenheit  - Location: MILK DISP
Violation Issued: Yes

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit  - Location: MEATBALLS IN TABLE
Violation Issued: No

Process/Item: Re-Heating
Temperature: 145 Degrees Fahrenheit  - Location: PACKED RIBS-INITIAL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit  - Location: BUNKER COOLER IN GARAGE AREA
Violation Issued: No

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

# Food and Beverage Establishment Inspection Report



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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8046221143 of 10/03/22.

Certified Food Protection Manager: PAM ZEA FLYNN

Certification Number: 17783 Expires: 01/05/24

Signed: _____

PAM FLYNN
MANAGER

Signed: Zach Johnson

Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us