DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 17, 2022

Administrator
Majestic Pines
1614 Golf Course Road
Grand Rapids, MN 55744

RE: Project Number(s) SL30986015

Dear Administrator:

On November 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 22, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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Electronically Delivered

October 17, 2022

Administrator
Majestic Pines
1614 Golf Course Road
Grand Rapids, MN 55744

RE: Project Number(s) SL30986015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 22, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30986	A. BUILDING: _____ B. WING _____	09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC PINES	1614 GOLF COURSE ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL30986015 On September 19, 2022, through September 22,2022, 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 84 residents, 47 of whom were receiving services under the provider's Assisted Living license. On September 20, 2022, the immediacy of correction order 0510 has been removed, however non-compliance remains at a scope and level of I (level 3, Widespread).	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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 19, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=I	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 an infection control program that complies with accepted health care, medical and nursing standards for infection control. This had the potential to affect all residents, staff and visitors. This resulted in an immediate correction order on September 19, 2022, at approximately 12:30 p.m. 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	0 510		

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0 510	Continued From page 3	0 510		

has affected or has potential to affect a large portion or all of the residents).
The findings include:
COVID-19 - ISOLATION
On September 19, 2022, at approximately 10:55 a.m. during a tour of the facility, director of nursing (DON)-B identified two residents in the memory care unit who were currently in isolation due to being COVID-19 positive. Outside of rooms 109 C and 111, there was a three drawer stand that contained clean PPE (personal protective equipment). Next to the stand was a garbage can where staff deposited their dirty PPE. DON-B stated after providing care to the residents in room 109 C and 111, staff would walk out of the room wearing their soiled PPE, remove the PPE in the hallway outside of the residents' room and place it in the garbage can in the hallway. There was no donning and doffing procedure found outside of rooms 109 C and 111 for reference.
On September 19, 2022, at approximately 3:00 p.m. DON-B provided a copy of the CDC (Center of Disease Control) guidelines pertaining to donning and doffing PPE. The CDC guidelines indicated to remove all PPE before exiting the patient's room.

EYE PROTECTION

On September 19, 2022, at approximately 10:50 a.m. during a tour with licensed assisted living director (LALD)-B and DON-B, staff were observed only wearing a mask when interacting with residents.

On September 19, 2022, at approximately 12:00 p.m. DON-B stated their county's community rate was low, so they were only wearing masks and using universal precautions. DON-B was not

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0 510	Continued From page 4 familiar with the county's community transmission rate. CDC (Center for Disease Control and Prevention) COVID-19 Data Tracker, for community transmission rate for Itasca county was "high," indicating a face mask and eye protection should be used when working with residents without suspected/confirmed COVID-19 infection. The licensee's Emergency-COVID Pandemic Plan revised July 2022, indicated eye protection should be worn based on county COVID transmission, during community COVID outbreak, and with residents in quarantine. TIME PERIOD FOR COMPLETION: Immediate. The immediacy is removed as confirmed by surveyors' on-site observation and review by evaluation supervisor on September 20, 2022, however, noncompliance remains at a scope and severity of I (level 3, Widespread). TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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.	0 800		

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0 800	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 21, 2022, between 10:00 a.m. and 12:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the electrical circuit breaker panel was not locked in resident room 112 in the dementia care unit. The LALD-A locked the panel before leaving room 112 and confirmed that the panel had not been secure during the tour interview. No further information was provided. TIME PERIOD FOR CORRECTION: One (1) day	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:	0 810		

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0 810	Continued From page 6 (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, document review, and interview, the licensee failed to maintain the plans for fire safety and evacuation. This had the potential to directly affect all 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	0 810		

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0 810	Continued From page 7 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 21, 2022, between 10:00 a.m. and 12:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, it was observed that the location and number of resident sleeping rooms were not legible on the evacuation plans posted in the facility. In an interview with the LALD-A during the tour, they confirmed that the resident room numbers were printed too small and that these plans required revision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 8 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 19, 2022, at approximately 9:30 a.m. during the entrance conference, a copy of the assisted living contract was requested. The assisted living contract included three clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 10, section 20, indicated 20. Personal Property. The resident agrees that Community is not responsible for a any loss or damage to resident's personal property due to any reason or cause, including theft, other than community's own negligence. Resident further agrees that community is not responsible for damage to resident's personal property due to fire, water, tornado, or other acts of nature and events beyond community control. Resident is strongly encouraged to obtain renters insurance. On September 20, 2022, at approximately 2:30 p.m. licensed assisted living director (LALD)-A and director of nurse (DON)-B both confirmed the assisted living contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 970		

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0 970	Continued From page 9 (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (R5). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 10 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: R5's diagnoses included hypothyroidism, mild dementia, and mild depression. R5's service plan dated August 26, 2022, indicated R5 required assistance with bathing, grooming, toileting, medication administration, housekeeping and laundry. R5's Progress Notes (written by licensed practical nurse/LPN) indicated the following: -June 18, 2022, at 12:54 p.m. this writer was notified by care specialist that the resident had a lump on the left forearm. This lump was discovered during a shower when the resident winced as the care specialist touched it. This writer evaluated the lump finding hard to the touch when the arm is flexed and approximately 3 cm (centimeters) x 2 cm. PRN (as needed) hydromorphone was given and evaluated as ineffective 40 minutes after administration. Resident also had a 10 cm bruise on the left arm on the side of the arm. There is a slight green color to this bruise causing this writer to suspect this bruise may be an old bruise. As well as a very faded bruise on the forearm. Lead administered another PRN hydromorphone and the resident is currently resting in her bed. RN notified via RTasks message. Family was notified and reported to this writer that the resident did	01620		

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	30986	A. BUILDING: _____ B. WING _____	09/22/2022

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01620	Continued From page 11 have a lipoma removed from one of her arms in the past but family could not recall which arm it was hospice was notified of this as well. -August 1, 2022, at 12:01 p.m. staff let this nurse know that tenant has a red, sore, tender to the touch spot on her ankle. It is not open, but closed over. I put a service on her schedule for skin treatment. Please be aware of this. R5's record lacked documentation to indicate the RN completed a reassessment of R5's change in condition. On September 20, 2022, at approximately 2:30 p.m. director of nursing (DON)-B confirmed a RN had not assessed the above changes to R5's condition as indicated above. The licensee's Initial and On-Going nursing assessment of Assisted Living Residents revised November 2021, indicated the RN will review the nursing assessment and service plan and, if necessary, will update the assessment and service plan, whenever the resident has returned from a hospital or nursing home stay, has a change in condition or experiences an incident such as a fall. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 12 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 medications were administered as ordered for one of five residents (R5). 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: R5's diagnoses included hypothyroidism, mild dementia, and mild depression. R5's service plan dated August 26, 2022, indicated R5 received assistance with medication administration.	01760		

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01760	Continued From page 13 On September 20. 2022, at approximately 8:45 a.m. the surveyor observed licensed practical nurse (LPN)-I administer the following medications to R5, crushed and mixed together in jelly, while R5 was sitting in the dining room eating breakfast: -acetaminophen (treatment of pain) 500 mg (milligrams) two (2) tablets; -Senokot (stool softener) 8.6 mg; and -levothyroxine (treatment of hypothyroidism) 50 mcg (micrograms). The pharmacy label for levothyroxine indicated the medications was to be administered before breakfast. R5's prescriber's order dated July 6, 2022, indicated levothyroxine 50 mcg, give before breakfast. On September 22, 2022, at approximately 2:30 p.m. director of nursing (DON)-B confirmed R5's levothyroxine should have been given before breakfast. The licensee's General Medication Policies reviewed August 2022, indicated the RN (registered nurse) or LPN will review medication systems and MAR (medication administration record)/EMAR (electronic medication administration record) daily, or as indicated in the resident's Individualized Medication Management Plan, to assure that all the daily medications were administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01910	Continued From page 14	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01910		

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01910	Continued From page 15 situation has occurred only occasionally). The findings include: R1's record lacked a disposition of medications to include: - prescription number as applicable; and - quantity R1 was admitted for services on January 21, 2018, and discharged to a smaller facility closer to family on July 15, 2022. R1's diagnoses included dementia, low back pain, diabetes, and hypertension (high blood pressure). R1's Service Plan dated July 12, 2022, noted R1 received mediation management services which included mediation administration. R1's July 2022, Mediation Administration Summary indicated R1 received the following scheduled medications: -acetaminophen 500 mg ES (for pain control) tablet three times daily; -amlodipine 9 (for high blood pressure) 10 mg daily; -Basaglar Kwikpen (insulin) 100 units/ml daily; - Losartan (for high blood pressure) 25 mg daily; -omeprazole (for heartburn) 20 mg daily; -risperidone (for dementia) 0.5 mg twice daily; -Senna (for constipation) 8.6 mg twice daily. R1's Discharge - Transfer Summary, medication disposition section dated July 15, 2022, noted all medications would be sent with the resident and documentation of disposition of medications was completed in licensee's medical software called RTasks.	01910		

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01910	Continued From page 16 R1's medication disposition form was opened up in RTasks and was blank. On September 19, 2022, at 2:35 p.m. director of nursing (DON)-B assisted the surveyor to open R1's medication disposition form in the RTasks software and confirmed the document was blank. DON-B stated she felt it was not completed. The licensee's Disposition or Disposal of Medications policy revised July 2021, indicated they follow MN Statute 144G.71, Subd. 22 and that staff will document in the resident's record the name of each medication and amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 17 by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 21, 2022, at 12:00 p.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on September 21, 2022, between 12:00 p.m. and 1:30 p.m. The hazard vulnerability assessment did not include hazards or safety risks identified on and around the property. On September 21, 2022, at approximately 1:30 p.m., the LALD-A confirmed during an interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 18 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure an oxygen cylinder was secured in a rack to prevent tipping or damage for one of one resident (R6). 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: The licensee failed to ensure an oxygen cylinder was secured in a rack to prevent tipping or damage. On September 20, 2022, at approximately 9:00 a.m. the surveyor observed a portable oxygen cylinder sitting along side of R6's bookcase unsecured. Unlicensed personnel (ULP)-G and ULP-H confirmed the oxygen tank was not secured in a rack to prevent tipping or damage. On September 21, 2022, at approximately 11:00 a.m. the MDH (Minnesota Department of Health) engineer and licensed assisted living director (LALD)-A observed three small oxygen cylinders in the mechanical room on the assisted living unit.	02310		

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02310	Continued From page 19 On September 21, 2022, at approximately 2:30 p.m. director of nursing (DON)-B stated R6's portable oxygen cylinder and the oxygen cylinders found in the mechanical room on the assisted living unit should have been secured to prevent them from falling over. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and	02410		

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02410	Continued From page 20	02410		

privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration, and blood glucose monitoring for two of five residents (R6 and R7).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On September 20, 2022, at approximately 7:45 a.m. the surveyor observed unlicensed personnel (ULP)-F to administer R7's Lantus Solostar insulin 12 units and six units of Novolog Insulin while R7 was sitting in a chair next to the medication cart in the hallway. There was another resident in the area when R7 was observed to pull down R7's pants to uncover R7's abdomen so ULP-F could administer R7's insulin.

On September 20, 2022, at approximately 9:25 a.m. the surveyor observed R6 sitting in a wheel chair in the hallway across from R7 who was

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02410	Continued From page 21 sitting in the chair next to the medication cart. Licensed practical nurse (LPN)-I performed R6's blood glucose monitoring while R6 was sitting in the hallway within view of R7. R6 was then brought to the dining room table to eat breakfast. LPN-I administered R6's Lantus 22 units and 6 units Novolog while sitting at the table with R8. On September 20, 2022, at approximately 2:30 p.m. director of nursing (DON)-B confirmed medication administration, and blood glucose monitoring should have been completed in a private area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/19/22*
Time: 14:27:02
Report: 7939221170

Food and Beverage Establishment Inspection Report

Location:
Majestic Pines
1614 Golf Course Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0037520
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189997776
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.

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

3-304.12G

MN Rule 4626.0275G Store the bulk food dispensing utensil in the food with the handle extending out of the food, or in a protective enclosure attached or adjacent to the enclosure with the utensil on a tether of easily cleanable material which is short enough to prevent the utensil from making contact with the floor.

CUPS STORED LYING ON THE CEREAL. CUPS REMOVED DURING INSPECTION

Corrected on Site

Surface and Equipment Sanitizers

ECOLAB SINK AND SURFACE: = at Degrees Fahrenheit
Location: PPM WITHIN LIMITS - RAG BUCKET
Violation Issued: No

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SOUP
Temperature: 147 Degrees Fahrenheit - Location: STEAM TRAY
Violation Issued: No

Process/Item: BRISKET
Temperature: 142 Degrees Fahrenheit - Location: STEAM TRAY
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: EGGS
Temperature: 41 Degrees Fahrenheit - Location: PREP TOP - TOP
Violation Issued: No

Process/Item: COLE SLAW
Temperature: 40 Degrees Fahrenheit - Location: PREP TOP - BOTTOM
Violation Issued: No

Process/Item: HAM
Temperature: 39 Degrees Fahrenheit - Location: UPRIGHT RIDGE
Violation Issued: No

Process/Item: PUDDING
Temperature: 38 Degrees Fahrenheit - Location: GLASS DOOR FRIDGE
Violation Issued: No

Process/Item: BRISKET
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN
Violation Issued: No

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

DISCUSSION
HAND WASHING AND GLOVE USE

DISH WASHER TEMPERATURE MONITORING

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 7939221170 of 09/19/22.

Certified Food Protection Manager: DENNIS REIFF

Certification Number: FM25463 Expires: 06/19/25

Signed: _____
DENNIS REIFF
MANAGER

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