DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 27, 2023

Licensee
Ely Carefree Living
140 South 2nd Avenue West
Ely, MN 55731

RE: Project Number(s) SL25891015

Dear Licensee:

On April 10, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 15, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

March 8, 2023

Licensee
Ely Carefree Living
140 South 2nd Avenue West
Ely, MN 55731

RE: Project Number(s) SL25891015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 15, 2023, 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.

LICENSING ORDERS
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 - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter

as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25891	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELY CAREFREE LIVING	140 SOUTH 2ND AVENUE WEST ELY, MN 55731

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25891015 On February 13, 2023, through February 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 39 active residents; all of whom were receiving services under the Assisted Living with Dementia Care 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 13, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	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	0 510		

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0 510	Continued From page 2 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 ensure infection control standards were followed to disinfect reusable resident equipment by one of one employee (unlicensed personnel (ULP)-J). 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 February 14, 2023, at 8:04 a.m., the evaluator observed ULP-J remove an Sp02 monitor (a noninvasive device that measure the oxygen saturation level of the blood), temporal thermometer, and blood pressure cuff from a basket sitting on the counter in the licensee's kitchen. ULP-J completed R9's vital signs with the above equipment and then placed the equipment back into the basket. ULP-J did not disinfect the SP02 monitor, temporal thermometer or blood pressure cuff prior to or after equipment use. ULP-J stated she did not disinfect the equipment before or after use and normally would use an	0 510		

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0 510	Continued From page 3 alcohol wipe or disinfectant wipe. On February 14, 2023, at 9:50 a.m., director of patient care and complaints/registered nurse (DPCC/RN)-B stated it would be expected of the ULP's to clean vital sign equipment before and after use with a disinfectant wipe. The licensee's Training and Competency of Unlicensed Staff dated January 16, 2023, indicated training and evaluation for all ULP's must include basic infection control and maintenance of a clean and safe environment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 4 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and post the EPP prominently. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 13, 2023, at 11:56 a.m., a facility tour was conducted with resident assisted living director (RALD)-A. The evaluator did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility and RALD-A confirmed the findings. The licensee's EPP lacked the following content and/or policies and procedures to address: - a comprehensive program to include infectious diseases and pandemics;	0 680		

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0 680	Continued From page 5 - a description of the population served by the licensee to identify at risk populations; - subsistence needs for staff and residents during an emergency to include (medical supplies, pharmacy supplies, sewer and waste disposal); - shelter in place to meet the needs of the residents; - the facility's role in providing care and treatment at alternative sites; - missing persons policy that was reviewed quarterly; - EP testing/annual requirements; and -written arrangements with other facilities or providers In addition, the licensee lacked a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; and - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies On February 14, 2023, at 9:48 a.m., the evaluator reviewed the licensee's EPP with director of patient care and complaints/registered nurse (DPCC/RN)-B. DPCC/RN-B stated the licensee's EPP was still being developed with all required content and was not completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 6 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 14, 2023, at approximately 10:30 a.m. with resident assisted living director (RALD)-A and maintenance (M)-G, it was observed that the lavatory sink in the Spa Room of the Assisted Living (south) building was not securely attached to the wall.	0 800		

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0 800	Continued From page 7 On the same tour in the Assisted Living (south) building a hole in the interior drywall membrane near the sprinkler pipe above the door in the mechanical room was observed. The interior fire-resistant rated membrane of the mechanical room is required to be maintained as designed. It was also observed an electrical box cover was missing, exposing the electrical wires in the box in the mechanical room of the Assisted Living (south) building. A light fixture cover was observed missing, exposing the internal wires and electrical parts of the fixture in resident room 110 of the memory care (north) building. A wooden gate with lockable hardware was observed in the corridor leading to a marked exit near the kitchen and laundry room in the memory care (north) building. The corridor/ means of egress is required to be maintained without obstructions that effect its full and immediate use. An exterior gate was observed with lockable hardware on the outside of the gate in the secured exterior area for the memory care (north) building. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors. Exterior gates were observed with lockable hardware on the outside of the gate in the fenced area between the middle building and the memory care (north) building. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors.	0 800		

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0 800	Continued From page 8 These deficient conditions were visually verified by RALD-A and M-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 9 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted on February 14, 2023, at approximately 11:30 a.m. of documents provided by resident assisted living director (RALD)-A and maintenance (M)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows:	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by RALD-A and M-G during the interview at approximately 11:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information	0 930		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	Continued From page 11 (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R5). This had the potential to affect all 39 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 930		

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	25891	A. BUILDING: _____ B. WING _____	02/15/2023

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0 930	Continued From page 12 The findings include: R1 R1's diagnoses included diabetes, hypertension (high blood pressure), mild cognitive impairment, hemiplegia (muscle weakness or partial paralysis) affecting left non-dominant side and tremor. R1's service plan dated April 26, 2022, indicated services included medication and insulin administration, housekeeping, and laundry. R2 R2's diagnoses included Lewy body dementia (progressive decline in mental abilities), osteoarthritis, and hyperlipidemia (elevated cholesterol in the blood). R2's service plan dated February 1, 2023, indicated services included medication administration, bathing, toileting, dressing and transfers. R5 R5's diagnoses included hypertension, idiopathic progressive neuropathy (damage of sensory and motor nerves), trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), and osteoporosis (weak and brittle bones). R5's service plan dated November 15, 2022, indicated services included medication administration, assistance with dressing, grooming, catheter care, compression stockings, hearing aids, elevating extremities, transfers, housekeeping, and laundry. R1, R2 and R5's signed assisted living contracts dated April 26, 2022, February 1, 2023, and November 15, 2022, respectively, lacked the	0 930		

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0 930	Continued From page 13 following content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. On February 15, 2023, at 10:17 a.m., registered nurse (RN)-K reviewed the licensee's contract with the evaluator and confirmed the licensee's resident contracts/resident agreements were a template and the same for all residents. RN-K confirmed the licensee's contract did not include the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. The licensee's Transfer of Resident within Facility policy dated February 6, 2023, indicated the licensee may not transfer a resident without first obtaining the resident's consent to the transfer unless: -there are conditions that render the resident's room or private living unit uninhabitable; or -there is a change in facility operations as described in subdivision five (5). Subdivision 5. included situations where there is a curtailment, reduction, or capital improvement within a facility necessitating transfers, the facility must: -minimize the number of transfers it initiates to complete the project or change in operations; -consider individual resident needs and preferences; -provide reasonable accommodations for individual resident requests regarding the transfers; and -in advance of any notice to any residents, legal	0 930		

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0 930	Continued From page 14 representatives, or designated representatives, provide notice to the Office of Ombudsman for Long-Term Care and, the Office of Ombudsman for Mental Health and Developmental Disabilities of the curtailment, reduction, or capital improvement and the corresponding needed transfers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging	01500		

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01500	Continued From page 15 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (registered nurse (RN)-K).	01500		

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01500	Continued From page 16 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: RN-K was hired on April 13, 2015, and began providing assisted living services on August 1, 2021. RN-K's employee record did not include the following required annual training: -training on reporting of maltreatment of vulnerable adults; and -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights On February 15, 2023, at 9:58 a.m., RN-K reviewed her on-line training transcript and confirmed it did not include the above required topics. The licensee's Training and Competency of Unlicensed Staff policy dated January 16, 2023, indicated all staff performing direct care services will have annual training that includes reporting of maltreatment of vulnerable adults and review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. No further information was provided.	01500		

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01500	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 18 violation that has no potential to cause more than a minimal impact on the resident and does not affect 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). The findings include: On February 14, 2023, at 8:54 a.m., the evaluator observed unlicensed personnel (ULP)-J administer a medication to R2. R2's service plan dated February 1, 2023, indicated services included medication administration, bathing, toileting, dressing and transfers. R2's service plan did not include a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On February 15, 2023, at 10:04 a.m., registered nurse (RN)-K confirmed R2's service plan did not include a signature by the licensee to authenticate the service plan agreement. The licensee's Service Plan policy dated January 16, 2023, indicated the service plan shall include a signature or other authentication by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01650	Continued From page 19	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans included the required content for three of three residents (R1, R3, R5). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 20 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). Findings include: R1 R1's diagnoses included diabetes, hypertension (high blood pressure), mild cognitive impairment, hemiplegia (weakness or partial paralysis) affecting left non-dominant side and tremor. R1's service plan dated April 26, 2022, indicated services included medication and insulin administration, housekeeping, and laundry. R1's prescriber order dated August 26, 2022, included blood sugar checks before breakfast daily. On February 14, 2023, at 7:13 a.m., unlicensed personnel (ULP)-H was observed recording R1's blood glucose reading (previously taken by R1 at 6:30 a.m.) of 171 mg/dl (milligrams per deciliter) in R1's electronic medical record. ULP-H stated R1 checked her own blood glucose with the Libre monitor (a continuous blood glucose monitor device that does not require a finger poke) and staff record results for daily monitoring. R1's Medication Administration Record (MAR) dated January 1, 2023, through February 13, 2023, indicated R1's received blood glucose monitoring twice a day. R2	01650		

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01650	Continued From page 21 R2's diagnoses included Lewy body dementia (progressive decline in mental abilities), osteoarthritis, and hyperlipidemia (elevated cholesterol in the blood). R2's service plan dated February 1, 2023, indicated services included medication administration, bathing, toileting, dressing and transfers. R5 R5's diagnoses included hypertension, idiopathic progressive neuropathy (damage of sensory and motor nerves), trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), and osteoporosis (weak and brittle bones). R5's service plan dated November 15, 2022, indicated services included medication administration, assistance with dressing, grooming, catheter care, compression stockings, hearing aids, elevating extremities, transfers, heavy cleaning/apartment inspection weekly, light cleaning daily, and laundry two (2) loads per week. R1, R2 and R5's service plans did not include the following required content: -the method of monitoring assessments of the resident; and -the method of monitoring staff providing services. In addition, R1's service plan did not include a description of the service to be provided, the fees for services and the frequency of service to include daily blood glucose monitoring and changing the Libre device. On February 15, 2023, at 10:17 a.m., registered	01650		

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01650	Continued From page 22 nurse (RN)-K confirmed the licensee's service plan was a template and used for all residents and further confirmed the service plans were missing the required content note above. RN-K further stated all treatment and services provided should be indicated on the resident's service plan. The licensee's Service Plan policy dated January 16, 2023, indicated the service plan would include the following: -schedule and method for the next planned assessment; -schedule and method for the next planned monitoring of staff providing services; -description of the services provided; -fees for services provided; and -the frequency of each service provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730		

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01730	Continued From page 23 diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for three of three residents (R1, R2, 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) and was issued at a	01730		

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01730	Continued From page 24 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: During entrance conference on February 13, 2023, at 10:37 a.m., director of patient care and complaints/registered nurse (DPCC/RN)-B confirmed the licensee provided medication management services to the residents of the facility. R1 R1's diagnoses included diabetes, hypertension (high blood pressure), mild cognitive impairment, hemiplegia (muscle weakness or partial paralysis) affecting left non-dominant side and tremor. R1's service plan dated April 26, 2022, indicated services included medication and insulin administration, housekeeping, and laundry. R1's February's 2023, Medication Administration Record (MAR) indicated R1 received metoprolol succinate ER 50 milligrams (mg) (for high blood pressure) and directed to take R1's pulse before administering medication. R1's MAR lacked written parameters for R1's pulse and staff were to notify nursing. On February 14, 2023, at 7:13 a.m., unlicensed personnel (ULP)-H was observed monitoring R1's pulse and recording R1's pulse of 59 in the MAR. R1was observed administering R1's morning medications including metoprolol succinate 50 mg. On February 14, 2023, at 7:49 a.m., ULP-H	01730		

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01730	Continued From page 25	01730		

confirmed there were no written instructions in R1's record of when to notify the nurse after checking R1's pulse.

On February 14, 2023, at 7:52 a.m., licensed practical nurse (LPN)-D stated if a resident was taking metoprolol succinate, staff were to check the resident's pulse before administering the medication and if the pulse was below 50 to hold the medication and notify the nurse. LPN-D confirmed R1's medication record directed to check R1's pulse before administering metoprolol succinate; however, lacked further directions of when to notify the nurse. LPN-D stated the licensee had previously contacted R1's provider for parameters and R1's provider declined to set parameters for R1's pulse. LPN-D stated she was unsure why R1's MAR directed to check R1's pulse if there were no directions for staff of when to notify the nurse.

R2
R2's diagnoses included Lewy body dementia (progressive decline in mental abilities), osteoarthritis, and hyperlipidemia (elevated cholesterol in the blood).

R2's service plan dated February 1, 2023, indicated services included medication administration, bathing, toileting, dressing and transfers.

R5
R5's diagnoses included hypertension, idiopathic progressive neuropathy (damage of sensory and motor nerves), trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), and osteoporosis (weak and brittle bones).

R5's service plan dated November 15, 2022,

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01730	Continued From page 26 indicated services included medication administration, assistance with dressing, grooming, catheter care, compression stockings, hearing aids, elevating extremities, transfers, housekeeping, and laundry. R1, R2, and R5's records did not include procedures for staff of notifying the RN or appropriate licensed health professional when a problem arises with medication management services. In addition, R1's record did not include specific instructions related to the administration of R1's metoprolol succinate. On February 15, 2023, at 9:58 a.m., registered nurse (RN)-K confirmed the residents' records lacked the required content as indicated above. RN-K further stated R1's provider would not set parameters for R1's pulse; however, staff were still directed to check R1's pulse before administering R1's metoprolol succinate. The licensee's Medication Management Services policy revised January 16, 2023, indicated the facility would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: -documentation of specific resident instructions relating to the administration of medications; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01880	Continued From page 27	01880		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for two of three medication refrigerators. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on February 13, 2023, at 10:37 a.m., director of patient care and complaints/registered nurse (DPCC/RN)-B confirmed the licensee provided medication storage. 200 HOUSE MEDICATION REFRIGERATOR On January 13, 2023, at 12:59 p.m., the evaluator	01880		

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01880	Continued From page 28 observed the medication refrigerator in the 200 house with licensed practical nurse (LPN)-D. Located on the outside of the medication refrigerator were recorded temperature logs which were missing days of recorded temperatures. The refrigerator's internal thermometer indicated 39 degrees Fahrenheit (F). LPN-D stated the staff working the day shift were responsible for monitoring and recording daily medication refrigerator temperatures. LPN-D verified the refrigerator temperature logs lacked daily monitoring of temperatures and verified the following medications were being stored: -five (5) unopened Novolin 70/30 insulin pens (mix insulin containing intermediate and short-acting insulin); and -three (3) unopened bottles of latanoprost ophthalmic 0.005% eye drops (used to treat increased pressure in the eye). The 200 house medication refrigerator logs indicated the following: -January 1-31, 2023, contained 14 of possible 31 temperatures that were not recorded. 140 HOUSE MEDICATION REFRIGERATOR On January 13, 2023, at 1:07 p.m., the evaluator observed the medication refrigerator in the 140 house with LPN-D. Located on the outside of the medication refrigerator were recorded temperature logs which were missing days of recorded temperatures. The refrigerator's internal thermometer indicated 41 degrees F. LPN-D verified the refrigerator temperature logs lacked daily monitoring of temperatures and verified the following medications were being stored: -14 unopened Humalog Kwikpen (fast acting insulin) pens; -four (4) unopened Lantus Solostar (long-acting insulin) pen; and	01880		

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01880	Continued From page 29 -five (5) unopened Novolog (short acting insulin) pens. The 140 house medication refrigerator logs indicated the following: -December 1-31, 2022, contained five (5) of possible 31 temperatures that were not recorded; and -January 1-31, 2023, contained eight (8) of possible 31 temperatures that were not recorded. On February 15, 2023, at 10:17 a.m., registered nurse (RN)-K stated she was informed there were missing recorded entries in the medication refrigerator logs. RN-K further stated staff would be receiving additional education and training on the importance of monitoring and recording refrigerator temperatures that store temperature sensitive medications. The manufacturer's instructions for Novolin 70/30 insulin pen dated November 2022, indicated to store unopened insulin pens in the refrigerator 36-46 degrees F. Do not allow the Novolin to freeze. The manufacturer's instructions for Xalantan (latanoprost ophthalmic solution) dated August 2011, indicated to store unopened bottle(s) under refrigeration between 36-46 degrees F. The manufacturer's instructions for Humalog Kwikpen insulin dated November 2019, indicated unopened Humalog should be stored in a refrigerator 36-46 degrees F but do not allow to freeze. Humalog prefilled pens should be stored at room temperature must be used within 28 days or be discarded. The manufacturer's instructions for Lantus	01880		

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01880	Continued From page 30 Solostar insulin pen revised June 4, 2022, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog insulin pen dated March 2021, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the Novolog to freeze. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label for R1, R8. In addition, the licensee failed to date time-sensitive medications with opened or expiration dates for R10. 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	01890		

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01890	Continued From page 31	01890		

cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

ORIGINAL PRESCRIPTION LABEL
On February 13, 2023, at 12:43 p.m., the evaluator observed the medication cart in the 200 house with unlicensed personnel (ULP)-E. ULP-E confirmed R1's opened Novolin 70/30 insulin pen (mixed of intermediate and short acting insulin) lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. ULP-E stated R1's insulin pen should have a prescription label.

On February 13, 2023, at 12:57 p.m., licensed practical nurse (LPN)-D stated some of the resident's insulins were without labels because the pharmacy would not put prescription labels on each individual insulin pen and will only put the prescription label on the original box.

ORIGINAL PRESCRIPTION LABEL/TIME SENSITIVE MEDICATION
On February 13, 2023, at 1:04 p.m., the evaluator observed the medication cart in the 140 house with licensed practical nurse LPN-D. LPN-D confirmed the following:
-R7's opened Humalog Kwik insulin pen (fast-acting insulin) lacked an original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it

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01890	Continued From page 32 had been issued; and -R10's opened Breo Ellipta (corticosteroid inhaler) 100/25 micrograms (mcg) inhaler was in its original box with a sticker on the box that directed to discard 45 days after opened. R10's Ellipta inhaler and original box lacked the date the inhaler was opened and when the inhaler would expire. During the above observation, LPN-D stated R7's Humalog Kwik insulin pen prescription label was on the original insulin box in the medication refrigerator. LPN-D stated she contacted R7's pharmacy and requested prescription labels to be put on each individual insulin pens. LPN-H stated R7's pharmacy was unable to full-fill the request and would only put the prescription label on the original box. LPN -D obtained R7's box of Humalog Kwik insulin pens from the medication refrigerator and inside the box each insulin pen had an original prescription label. LPN-D stated she didn't know the pharmacy put labels on the insulin pens. LPN-D further stated it was their practice to write the date the time-sensitive medications were opened on insulins; eye drops and inhalers. The manufacturer's instructions for Breo Ellipta inhaler directed once the tray of the inhaler was opened to write the date on the inhaler and discard six (6) weeks after inhaler was opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 33 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include a written statement of the treatment or therapy services to be provided on the service plan for one of three residents (R1).	01940		

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01940	Continued From page 34 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: During entrance conference on February 13, 2023, at 10:37 a.m., director of patient care and complaints/registered nurse (DPCC/RN)-B confirmed the licensee provided treatment and therapy services to residents. R1's diagnoses included diabetes. R1's service plan dated April 26, 2022, did not indicate R1 received treatment or therapy services to include blood glucose monitoring or changing R1's Libre device (a continuous blood glucose monitoring device that does not require a finger poke). R1's prescriber order dated August 26, 2022, included blood sugar checks before breakfast daily. On February 14, 2023, at 7:13 a.m., unlicensed personnel (ULP)-H was observed recording R1's blood glucose reading of 171 mg/dl (milligrams per deciliter) in R1's electronic medical record. ULP-H stated R1 checked her own blood glucose with the Libre monitor and staff record results for daily monitoring. R1's Medication Administration Record (MAR)	01940		

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01940	Continued From page 35 dated January 1, 2023, through February 13, 2023, indicated R1's received blood glucose monitoring twice a day. R1's Progress Notes dated January 16, 2023, indicated licensed practical nurse (LPN)-D placed the Libre sensor on the back of R1's left upper arm and the sensor was to be replaced every two (2) weeks. R1's Treatment/Therapy Management Plan dated January 31, 2023, included blood sugar checks; however, R1's treatment plan did not include changing the Libre device and further lacked a written statement of treatment services provided on R1's service plan. On February 14, 2023, at 1:52 p.m., LPN-D stated R1's Libre device was new, and LPN-D placed the Libre sensor on the back of R1's left arm on January 24, 2023. LPN-D stated the Libre sensor was changed every 14 days and confirmed the treatment of services provided were not on R1's treatment plan or service agreement. On February 14, 2023, at 2:03 p.m., registered nurse (RN)-K stated R1 was independent with monitoring her own blood glucose levels until she became symptomatic, at which time, RN-K initiated staff to record R1's blood glucose level daily for monitoring. RN-K stated the plan was for R1 to become independent in changing her own Libre sensor. RN-K confirmed R1's treatment plan did not include a statement of treatments being provided on R1's service plan. On February 15, 2023, at 10:25 a.m., R1 stated she checked her own blood glucose twice a day with the Libre device and staff recorded the	01940		

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01940	Continued From page 36 results. R1 stated LPN-D changed her Libre device every 14-days. The licensee's Treatment and Therapy Management Services policy revised January 16, 2023, indicated each resident receiving management of an orders or prescription for treatments or therapy services, the licensee would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident. The facility would also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960		

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01960	Continued From page 37 by: Based on observation, interview and record review, the licensee failed to ensure specific written instructions for each resident were documented in three of three resident's records (R1, R7, R8) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on February 13, 2023, at approximately 10:37 a.m., director of patient care and complaints/registered nurse (DPCC/RN)-B confirmed the licensee provided blood glucose (sugar) monitoring. R1 R1's diagnoses included diabetes. R1's service plan dated April 26, 2022, indicated services included medication and insulin administration, housekeeping, and laundry. R1's service plan did not include blood glucose monitoring. R1's prescriber order dated August 26, 2022, included blood glucose checks before breakfast daily. R1's Treatment/Therapy Management Plan dated	01960		

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01960	Continued From page 38 January 31. 2023, included blood glucose checks. R1's Medication Administration Record (MAR) dated January 1, 2023, through February 13, 2023, indicated R1 received blood glucose monitoring twice a day. On February 14, 2023, at 7:22 a.m., unlicensed personnel (ULP)-H was observed recording R1's blood glucose reading of 171 mg/dl (milligrams per deciliter) in R1's electronic medical record (EMR). ULP-H verified R1's record did not include blood glucose parameters of when to notify the nurse. R7 R7's diagnoses included diabetes and dementia. R7's service plan dated January 5, 2023, indicated services to include blood glucose checks. R7's prescriber orders dated December 13, 2022, included blood glucose checks twice a day. R7's Treatment/Therapy Management Plan dated January 31, 2023, included blood glucose checks. R7's MAR dated January 1, 2023, through February 13, 2023, indicated R7's received blood glucose monitoring twice a day. R7's MAR lacked blood glucose parameters of when to notify the nurse. On February 14, 2023, at 7:33 a.m., the evaluator observed ULP-I obtain R7's blood glucose via blood glucose meter (a medical device that measures the sugar in the blood).	01960		

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01960	Continued From page 39 R8 R8's diagnoses included diabetes. R8's service plan dated August 2, 2022, indicated services included blood glucose checks. R8's prescriber orders dated December 14, 2022, included blood glucose checks four (4) times a day and to report blood glucose below 100 to nursing. R8's Treatment/Therapy Management Plan dated January 31, 2023, included blood glucose checks. R8's MAR dated January 1, 2023, through February 13, 2023, indicated R8's received blood glucose monitoring four (4) a day and to report blood sugar below 100 to nursing. R8's MAR did not include parameters for when to report an elevated blood glucose. R1, R7 and R8's record lacked specific written instructions to include parameters for monitoring blood glusose results. On February 14, 2023, ULP-I stated she could not find written blood glucose parameters in R1 and R7's record and stated R8 had instructions to notify the nurse if R8's blood glucose was below 100 mg/dl. ULP-I stated there use to be a small sign posted with blood glucose parameters but was unable to locate. On February 14, 2023, at 7:47 a.m., licensed practical nurse (LPN)-H confirmed R1 and R7 records lacked blood glucose parameters of when to notify the nurse and further confirmed R8's record directed to only notify the nurse of a	01960		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 40 blood glucose below 100 mg/dl. On February 15, 2023, at 10:17 a.m., registered nurse (RN)-K stated she contacted R1, R7 and R8's providers and obtained blood glucose parameters for when to notify the nurse and added the written instructions to R1, R7 and R8's MAR's. RN-K confirmed R1, R7 and R8's records previously lacked blood glucose parameters. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treat/therapy is delegated or assigned to unlicensed personnel, the licensee would ensure the RN has specified in writing specific instructions for each resident and documented those instructions in the resident's record. The licensee's Blood Glucose Monitoring policy revised January 16, 2023, directed to record glucose readings on the resident MAR or flowsheet. Staff should follow individual instructions noted on the MAR or flowsheet for readings that may require staff intervention. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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:	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25891	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELY CAREFREE LIVING	140 SOUTH 2ND AVENUE WEST ELY, MN 55731

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02040	Continued From page 41 (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 by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted February 14, 2023, at approximately 11:30 a.m. with resident assisted living director (RALD)-A and maintenance (M)-G on the hazard vulnerability assessment for the physical environment of the facility. During interview, RALD-A and M-G provided documentation of a general hazard vulnerability assessment but had not conducted a hazard	02040		

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	25891	A. BUILDING: _____ B. WING _____	02/15/2023

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02040	Continued From page 42 vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. This condition was verified by RALD-A and M-G during the interview at approximately 11:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and	02110		

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02110	Continued From page 43 intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives for two of three residents (R1, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license for a capacity of 46 residents. R1 R1's diagnoses included diabetes, hypertension (high blood pressure), mild cognitive impairment, hemiplegia (muscle weakness or partial paralysis) affecting left non-dominant side and tremor.	02110		

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	25891	A. BUILDING: _____ B. WING _____	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 44 R1's Resident Acknowledgement Form dated August 1, 2021, did not indicate the required dementia care policies were provided or offered to the resident and/or resident's legal or designated representative. R5 R5's diagnoses included hypertension, idiopathic progressive neuropathy (damage of sensory and motor nerves), trigeminal neuralgia (chronic pain condition affecting the trigeminal nerve in the face), and osteoporosis (weak and brittle bones). R5's Resident Acknowledgement Form dated August 4, 2021, did not indicate the dementia care policies and procedures were provided or offered to the resident and/or the resident's legal or designated representative. R1 and R5 records did not include evidence or documentation the resident and/or resident's representative had received the policies and procedures related to dementia care as required. On February 14, 2023, director of patient care and complaints/registered nurse (DPCC/RN)-B stated the residents did not have signed acknowledgement indicating the additional dementia care policies were offered or provided to the resident and/or residents' representative. DPCC/RN-B stated the licensee was in the process of updating the Resident Acknowledgement Form provided at the time of move-in to include the dementia care polices. On February 15, 2023, at 9:58 a.m., registered nurse (RN)-K stated the licensee had only been providing the dementia care policies to residents on the memory care unit and after learning the	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25891	A. BUILDING: _____ B. WING _____	02/15/2023

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02110	Continued From page 45 requirement, RN-K stated moving forward the licensee would be offering the dementia care policies to all residents and/or the residents' legal or designated representative at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings;	02170		

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02170	Continued From page 46 (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a comprehensive evaluation for activities and an individual activity plan (IAP) for one of one resident (R2) who received services under an assisted living with dementia care license. 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 was licensed as an assisted living with dementia care facility on August 1, 2022. R2's diagnoses included Lewy body dementia (progressive decline in mental abilities), osteoarthritis, and hyperlipidemia (elevated cholesterol levels in the blood).	02170		

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02170	Continued From page 47 On February 14, 2023, at 8:54 a.m., the evaluator observed unlicensed personnel (ULP)-J administer a medication to R2. R2's assessment dated February 10, 2023, lacked the following required content for an individualized activity evaluation: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; and -identification of activities for behavioral interventions In addition, R2's record lacked the development of an individualized activity plan based on the assessment. On February 15, 2023, at 10:15 a.m., registered nurse (RN)-K confirmed R2's record lacked a comprehensive activity evaluation and an activity plan that addressed all the required content noted above. The licensee's Life Enrichment Programs, Activities and Outdoor Space policy dated January 16, 2023, indicated the comprehensive assessment will address the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; and -identification of activities for behavioral interventions No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *02/13/23*
Time: 10:30:53
Report: 1032231023

Food and Beverage Establishment Inspection Report

Location:
Ely Carefree Living - Lincoln
100 South 2nd Avenue West
Ely, MN55731
St. Louis County, 69

Establishment Info:
ID #: 0021984
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Ely Senior Housing and Service

Phone #: 6514510569
ID #: 42981

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE A THIN PROBE THERMOMETER

Comply By: 02/27/23

4-300 Equipment Numbers and Capacities

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

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

PROVIDE TEST KIT FOR DISHWASHER

Comply By: 02/27/23

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: TURKEY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: AMERICAN CHEESE
Violation Issued: No

Type: Full
Date: *02/13/23*
Time: 10:30:53
Report: 1032231023
Ely Carefree Living - Lincoln

Food and Beverage Establishment Inspection Report

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

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

ALL FOOD IS BROUGHT IN DAILY FROM FACILITY IN BABBITT.

NO COOKING, OR BAKING, IS DONE ON SIGHT.

LEFTOVERS ARE EITHER DISCARDED OR USED WITHIN A DAY OR TWO

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

I acknowledge receipt of the MDH inspection report number 1032231023 of 02/13/23.

Certified Food Protection Manager: BETTY N PFIFFNER

Certification Number: FM88947 Expires: 05/02/23

Signed: _____
LISA HOFF
ALDIR

Signed: _____
Ben Kubes
Environmental Health Specialist
Duluth
ben.kubes@state.mn.us

Report #: 1032231023

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	0	Date	02/13/23
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:53
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Ely Carefree Living - Lincoln	100 South 2nd Avenue West	Ely, MN	55731	6514510569

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0021984	Ely Senior Housing and Service	Full		M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/13/23

Inspector (Signature)