Electronically Delivered

March 29, 2023

Licensee
Elysian Senior Homes of Duluth
110 Coffee Creek Boulevard
Duluth, MN 55811

RE: Project Number(s) SL36629015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 8, 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 . . ."

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

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

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
State Evaluation Team
Health Regulation Division
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: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36629	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF DULUTH	110 COFFEE CREEK BOULEVARD DULUTH, MN 55811

(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: SL36629015-0 On March 6, 2023, through March 8, 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 31 active residents receiving services under the Assisted Living 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 March 6, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	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 and interview, the licensee failed to ensure reusable equipment was cleaned in-between resident use. In addition, the licensee failed to ensure infection control standards were followed by one of three unlicensed personnel ((ULP)-D) during medication administration for R8 and R15. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DISINFECTING EQUIPMENT BETWEEN USE On March 7, 2023, at 8:12 a.m., the evaluator observed ULP-C remove a blood pressure cuff from the side of medication cart #2 in the memory care unit. ULP-C applied the blood pressure cuff to R14's upper right arm and proceeded to take R14's blood pressure. On March 7, 2023, at 8:18 a.m., ULP-C placed the blood pressure cuff on a table in the common's area.	0 510		

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0 510	Continued From page 3 On March 7, 2023, at 9:25 a.m., ULP-C stated the blood pressure cuff was left out because other residents needed to have their blood pressure taken that day. On March 7, 2023, at 9:48 a.m., an unidentified staff moved the blood pressure cuff from the table and placed it on the top of medication cart #2. On March 7, 2023, at 9:55 a.m., the evaluator asked ULP-C the process to clean the blood pressure cuff. ULP-C hesitated and replied, "I have never seen anyone clean it [blood pressure cuff]." On March 8, 2023, at 11:34 a.m., registered nurse (RN)-B confirmed the blood pressure cuff should be cleaned "in-between" residents, "cleaned after each use." The licensee's Cleaning of Shared Medical Equipment revised August 1, 2021, indicated all reusable resident care equipment was routinely cleaned, and when appropriate, disinfected, before and after reuse. Common shared resident care equipment may include: stethoscopes, glucometers not limited to individual resident use, mechanical lifts, and etc. MEDICATION ADMINISTRATION R8 On March 7, 2023, at 7:17 a.m., the evaluator observed ULP-D prepare R8's morning medication. During the process, ULP-D removed two acetaminophen tablets 500 milligrams (mg) from a medication bottle and put the medication directly into her [ULP-D's] bare hand then added the pills into a medication cup. ULP-D took the medication cup to R8's room and administered	0 510		

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0 510	Continued From page 4 the medication to R8. R15 On March 7, 2023, at 9:04 a.m., the evaluator observed ULP-D open a medication bottle and put the medication directly into her bare hand. ULP-D then transferred the medication into a medication cup. ULP-D took the medication cup to R15's room and administered the medications to R15. On March 7, 2023, at 11:35 a.m., RN-B confirmed medications should be "tapped" into a medication cup. RN-B added staff should not touch medications with their bare hands, and if medications needed to be touched, gloves should be worn. On March 8, 2023, at approximately 9:30 a.m., RN-B identified herself as being the person assigned to oversee infection prevention and control for the facility. The licensees Delegation of Assisted Living Services policy revised August 1, 2021, indicated when the registered nurse or licensed health professional at [name of facility] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate that ability to competently follow the procedures and perform the tasks. When performing medication management services, medication reminders, assistance, or administration. When medication management is delegated to a ULP, the RN will: - instruct the unlicensed personnel in the proper methods to administer the medications; -verify the unlicensed personnel has	0 510		

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0 510	Continued From page 5 demonstrated the ability to competently follow the procedures; -specify, in writing, specific instructions for each resident and document those instructions in the resident's record; and -communicate with the unlicensed personnel about the individual needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines	0 660		

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0 660	Continued From page 6 issued by the Centers for Disease Control and Prevention (CDC) which included the completion of baseline TB screenings such as a blood test was completed for one of three employees (unlicensed personnel (ULP)-C). 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 the entrance conference on March 6, 2023, at 10:29 a.m., the evaluator asked for the licensee's facility TB risk assessment, which was provided to and later reviewed by the evaluator. The facility TB risk assessment was dated November 3, 2022. The facility had been identified as low risk. ULP-C had a hire date of August 3, 2022. ULP-C's employee record included a completed Baseline TB Screening for Health Care Workers (HCWs) dated August 3, 2022. ULP-C's employee record did not include a IGRA (serum blood test) or TST (first step) dated within 90 days of hire. On March 8, 2023, at 9:55 a.m., licensed assisted living director (LALD)-A confirmed the facility did not have a blood serum test for ULP-C, which was used for TB screening at the facility. In	0 660		

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0 660	Continued From page 7 addition, LALD-A stated they had contacted the clinic used by the facility for testing and the clinic stated they did not have a serum test in their system for ULP-C. LALD-A added the licensee sent ULP-C to the clinic for a blood serum test following the discovery. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. The licensee's Tuberculosis Screening policy revised August 1, 2021, indicated staff whose essential job functions required work within the same air space of home care clients [residents] would be screened and tested for TB prior to the staff being exposed to clients. New staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No staff would be permitted to begin work where the work involves shaping the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result was received and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (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 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. 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	0 680		

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0 680	Continued From page 9 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). During the entrance conference on March 6, 2023, at 10:33 a.m., the evaluator asked for the licensee's EPP, which was provided to and later reviewed by the evaluator. The licensee's EPP failed to include the following: - process for EP cooperation and collaboration with tribal, regional, state, and federal officials/organizations; - development of policies/procedures to address: - shelter in place; - emergency staffing strategies to include volunteers; and - contact information for ombudsman. On March 8, 2023, at approximately 8:15 a.m., vice president (VP)-J and licensed assisted living director (LALD)-A confirmed the facility's EPP was not fully developed as required. VP-J and LALD-A stated they thought the facilities EPP plan was complete. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy revised August 1, 2021, indicated the facility's emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 800	Continued From page 10	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 March 7, 2023, at approximately 11:00 a.m. with director of maintenance (DM)-F, director of maintenance (DM)-G and building maintenance and grounds assistant (BMG)-H, a leak in the ceiling of the mechanical room/ maintenance office was observed.	0 800		

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0 800	Continued From page 11 It was also observed that a toilet attachment to the floor was loose in the spa in memory care unit. A portable electric space heater was observed plugged in with an extension cord in resident room 111. Portable electric space heaters are required to be installed and used in accordance with the manufactures instructions and plugged directly into an electrical outlet. Storage was observed in the marked means of egress corridor near the mechanical room/ maintenance office and commercial kitchen on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an emergency. These deficient conditions were visually verified by DM-F, DM-G and BMG-H 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,	0 810		

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0 810	Continued From page 12 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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	36629	A. BUILDING: _____ B. WING _____	03/08/2023

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0 810	Continued From page 13 A record review of available documentation and interview were conducted on March 7, 2023, at approximately 10:00 a.m. of documents provided by licensed assisted living director (LALD)-A, vice president of policy and compliance (RN)-I, vice president (VP)-J, director of maintenance (DM)-F, director of maintenance (DM)-G and building maintenance and grounds assistant (BMG)-H 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 have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. All deficiencies were verified by LALD-A, RN-I, VP-J, DM-F, DM-G and BMG-H during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under	0 820		

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0 820	Continued From page 14 chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on March 7, 2023, at approximately 11:15 a.m. with director of maintenance (DM)-F, director of maintenance (DM)-G and building maintenance and grounds assistant (BMG)-H, it was observed that a portable space heater was used in resident room 007 within the dementia care unit. Space heaters are not allowed in sleeping rooms of dementia care units.	0 820		

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0 820	Continued From page 15 This deficient condition was visually verified by DM-F, DM-G and BMG-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
0 950 SS=B	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer two of three residents (R2, R3) the opportunity to identify or decline a designated representative. 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 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: R2 R2's diagnoses included diabetes and mild cognitive impairment. R2's Service Plan Agreement dated January 9, 2023, indicated R2 received services which included medication administration, assistance with dressing, grooming, toileting, bathing, safety checks, laundry, and housekeeping. R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung disease), macular degeneration (a condition of the eye which causes vision loss), and high blood pressure. R3's Service Plan Agreement dated December 5, 2022, indicated R3 received services which included medication administration, assistance with dressing, grooming, transferring, toileting, bathing, oxygen assist, safety checks, laundry,	0 950		

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0 950	Continued From page 17 and housekeeping. R2 and R3's Assisted Living with Dementia Care contracts dated January 9, 2023, and December 5, 2022, respectively, included statutory language for the right to designate a representative; however, lacked an opportunity to identify a designated representative or document R2 or R3 declined to name a designated representative. On March 7, 2023, at 12:23 p.m., licensed assisted living director (LALD)-A reviewed R2 and R3's contracts and stated she could not find in the contracts where there was an opportunity to identify or decline a designated representative including the signature page 68 of the contract. The licensee's Designated Representative policy dated August 1, 2022, indicated the licensee would offer resident the opportunity to identify a designated representative in writing. A signed designated representative form would be filled out documenting the residents' choice in designated representative, the form would be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.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	0 970		

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0 970	Continued From page 18 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 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 (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 the potential to affect a large portion or all the residents). The findings include: During entrance conference on March 6, 2023, at 9:43 a.m., the evaluator requested a copy of the licensee's assisted living contract. The licensee's Assisted Living with Dementia Care contract included a clause indicating the resident would waive the facility's liability for health, safety, or personal property of the resident. Pages three (3) and four (4), section seven (7), under Term of contract, increase in monthly rent, payment due dates, late fees, termination, and related issues of the assisted living contract indicated if, for reasons beyond the licensee's control, the licensee cannot provide all features and services on the date of possession, the resident agrees that neither "The company" or	0 970		

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0 970	Continued From page 19 the licensee are liable to the resident or others for any resulting damages and that the resident sole remedy will be a pro rata reduction in rent and other charges due under the contract until the licensee is able to provide those features and services. On March 7, 2023, at 12:23 p.m., licensed assisted living director (LALD)-A confirmed the assisted living contract provided was the same contract used for all residents. LALD-A reviewed pages three (3) and four (4) of the contract, and further stated she was unable to interrupt the language noted above and would have to contact the corporate office for further clarification. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01640 SS=E	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	01640		

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01640	Continued From page 20 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 was revised to reflect the current services provided for two of three residents (R2, R11). 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: R2 R2's diagnoses included diabetes and mild cognitive impairment. On March 7, 2023, at 8:29 a.m., the evaluator observed unlicensed personnel (ULP)-E checking R2's blood glucose with R2's blood glucose monitoring device and documented a reading of 170 mg/dl (milligrams per deciliter). R2's Service Plan Agreement dated January 9, 2023, indicated R2 received services which	01640		

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01640	Continued From page 21 included medication administration, housekeeping, laundry, assistance with dressing, grooming toileting, and bathing. R2's Service Plan did not indicate R2 received blood glucose monitoring. R2's 14-day Uniform Assisted Living Assessment dated January 24, 2023, included scheduled blood sugar checks twice a day. R2's Medication Administration Record (MAR) dated February 1, 2023, through March 7, 2023, indicated R2's received blood glucose monitoring twice a day. R11 R11's diagnoses included down syndrome, dementia without behavioral disturbances, and gastro-esophageal reflux disease (GERD). R11's Service Plan Agreement authenticated on August 1, 2022, included weekly Hospice charting, every Wednesday, "Nurse to chart on hospice client [resident] condition weekly." Effective date February 11, 2022. R11's Progress Note dated January 31, 2023, included, "resident discharged from [name of company] Hospice today." On March 7, 2023, at 8:59 a.m., registered nurse RN-B stated R2 received blood glucose monitoring twice daily. Further, RN-B confirmed R2's Service Plan Agreement did not include blood glucose monitoring services being provided and it should have been indicated on the service plan. On March 8, 2023, at approximately 10:00 a.m., registered nurse (RN)-B confirmed R11's service	01640		

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01640	Continued From page 22 plan had not been revised when Hospice services were discontinued. RN-B added "one line changed, weekly RN charting." RN-B stated service plans are not updated with "minor" changes, and stated, "we don't have that many changes." The licensee's Service Plan policy revised August 1, 2022, indicated services plans and any revisions or updates would be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific	01750		

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01750	Continued From page 23 instructions for each resident and documented those instructions for one of three residents (R11). 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: R11's diagnoses included down syndrome, dementia without behavioral disturbances, and gastro-esophageal reflux disease (GERD). R11's Service Plan Agreement dated August 1, 2022, included medication administration four times daily. R11's medication administration record (MAR) dated March 1, 2023, through March 6, 2023, included omeprazole (GERD) 40 milligrams (mg), take one capsule by mouth twice daily. On March 7, 2023, at 7:57 a.m., the evaluator observed unlicensed personnel (ULP)-C remove R11's morning medication which included: two acetaminophen 500 milligram (mg) tablets, oxycodone HCl 5 mg tabs and omeprazole 40 mg. ULP-C opened the omeprazole capsule and placed the medication beads into the pill crusher which contained the other two medications. ULP-C then proceeded to crush these medications and administer the medication to R11 in applesauce.	01750		

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01750	Continued From page 24 On March 7, 2023, at 11:33 a.m., RN-B confirmed R11's MAR did not include specific instructions for omeprazole, to open capsule and then add medication beads to applesauce. The licensee's Delegation of Assisted Living Services policy revised August 1, 2021, indicated when medication management is delegated to a ULP, the RN would: instruct the unlicensed personnel in the proper methods to administer the medication: -verify the unlicensed personnel had demonstrated the ability to competently follow the procedures; -specify, in writing, specific instructions for each resident and document those instructions in the resident's record; and -communicate with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760		

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01760	Continued From page 25 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 medication was given per manufacturer's instructions for one of three resident's (R7) and the licensee failed to ensure the steps of the medication administration process was followed for two of two employees unlicensed personnel (ULP)-C, ULP-D, observed administering medications in the memory care unit. 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: MANUFACTURER'S INSTRUCTION R7 R7's diagnosis include glaucoma, agitation/anxiety, and dementia. R7's service plan dated January 1, 2023, indicated R7 received medication administration two times daily. R7's provider's orders dated February 15, 2023, included Timolol 0.5% eye solution every	01760		

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01760	Continued From page 26 morning. On March 7, 2023, at approximately 9:10 a.m., the evaluator observed ULP-C administer R7's morning oral medications and instill an eye drop in each of R7's eyes. ULP-C commented she was surprised R7 agreed to them, [eye drops] adding she refuses often, "ice cold." Directly following this observation ULP-C returned the bottle of Timolol eye solution to the memory care refrigerator. The evaluator inquired about the Timolol solution's storage and ULP-C pointed to a colored posting on the wall above the refrigerator which listed several eye medications including Timolol- "throw after 28 days (Refrigerate)." The word refrigerate was underlined. R7's February 1, 2023, through February 28, 2023, MAR indicated R7 received Timolol 0.5% eye solution twenty out of twenty-eight opportunities. On March 7, 2023, at 11:28 a.m., RN-B said "company" stated Timolol was to be kept in the refrigerator, they [the head office] had supplied the posting. RN-B added the cold temperature of the eye solution might have been why R7 refused the eye solution. The manufacturer's instruction for Timolol eye solution dated July 16, 2022, indicated store in an upright position at room temperature, do not freeze, store in a dry place. The licensee's Medication Storage policy revised August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).	01760		

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01760	Continued From page 27 PROCESS OF MEDICATION ADMINISTRATION R12 R12's diagnoses include weakness, and other symptoms and signs involving cognitive functions and awareness. R12's Service Plan Agreement dated January 1, 2023, indicated R12 received medication administration daily. R12's medication administration record (MAR) dated March 1, 2023, through March 7, 2023, at 8:00 a.m., included: -amlodipine (heart disease) 10 milligrams (mg); -aspirin 81 mg; -calcium 600 mg +vit D10 micrograms (mcg); -fexofenadine (allergies) 180 mg; -lisinopril (high blood pressure) 2.5 mg; and -Senna 8.6 mg+ docusate (bowel health) 50 mg. On March 7, 2023, at approximately 7:40 a.m., the evaluator observed ULP-C at a medication cart preparing R12's morning medications. The evaluator then observed ULP-C go into R12's room with a medication cup. On March 7, 2023, at 7:48 a.m., the evaluator observed R12 walk into room #11 to speak to ULP-C. R12 had a round white tablet in the palm of his hand. R12 asked ULP-C if it was his medication and if he should take it? ULP-C told R12 "this [round white medication] is yours, I gave it to you. You can take it. Did it drop?" R12 put the medication in his mouth and swallowed the tablet. On March 7, 2023, at 7:51 a.m., ULP-C stated, "I am pretty good at watching them [residents take medications]. I did not see it [medication] drop."	01760		

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01760	Continued From page 28 On March 7, 2023, at 8:07 a.m., ULP-C stated to ULP-D in a voice loud enough for the evaluator to hear, "I told on myself". "I went out and had a quick smoke and thought about it. I should have put the medication [R12's white pill] in an envelope." On March 7, 2023, at 11:29 a.m., registered nurse (RN)-B confirmed staff were to stay with residents to ensure all medications were taken as ordered. On March 8, 2023, at 8:53 a.m., RN-B stated a medication error occurred with R12's morning medication. The licensees Delegation of Assisted Living Services policy revised August 1, 2021, indicated when the registered nurse or licensed health professional at [name of facility] delegates tasks to unlicensed personnel, that person will ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate that ability to competently follow the procedures and perform the tasks. When performing medication management services, medication reminders, assistance, or administration. When medication management is delegated to a ULP, the RN will: -instruct the unlicensed personnel in the proper methods to administer the medications; -verify the unlicensed personnel has demonstrated the ability to competently follow the procedures; -specify, in writing, specific instructions for each resident and document those instructions in the resident's record; and -communicate with the unlicensed personnel	01760		

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01760	Continued From page 29 about the individual needs of the resident. R8 R8's diagnoses include congestive heart failure, hypertension, and mild cognitive impairment. R8's service plan dated January 1, 2023, included medication administration three times daily. On March 7, 2023, at 7:17 a.m., the evaluator observed ULP-D remove R8's morning oral medications and a vial of artificial tears from a locked medication cart. ULP-D documented the medications as given. On March 7, 2023, at 7:19 a.m., ULP-D asked R8 to go to her room where ULP-D administered the oral medications and instilled an eye drop into both of R8's eyes. On March 7, 2023, at 7:39 a.m., the evaluator observed ULP-D prepare and immediately administer another resident's medication. ULP-D then documented that resident's medication as given. On March 7, 2023, at 7:46 a.m., ULP-D confirmed R8's medications were documented as being administered prior to the medications being administered. ULP-D added she waited to document the other resident's medication administration since she [ULP-D] was not sure if the other resident would take the medications. On March 7, 2023, at 11:26 a.m., RN-B confirmed medication documentation should be done "right after" medication administration. The licensee's Medication Management-Administration & Setup policy	01760		

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01760	Continued From page 30 revised August 1, 2021, indicated documentation of a medication reminder, medication assistance or medication administration would be completed immediately after that task had been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	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 the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. In addition, the licensee failed to ensure medication was secured in a locked area for R15. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01880		

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01880	Continued From page 31 MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On March 6, 2023, at 10:38 a.m., the evaluator toured the facility with licensed assisted living director (LALD)-A, including a review of the refrigerator in the memory unit and assisted living unit of the facility. LALD-A asked unlicensed personnel (ULP) to review the contents with the evaluator. MEMORY CARE UNIT On March 6, 2023, at 11:06 a.m., housing coordinator (HC)-M stated the current temperature was 30 degrees in the locked refrigerator, adding "it is supposed to be 32". HC-M adjusted the refrigerator temperature after commenting "it is a little low." The refrigerator contained: -an opened bottle of Timolol 0.5% (glaucoma medication/ high eye pressure) for R7; and -an unopened bottle of latanoprost 0.05% eye drops (glaucoma medication) for R8. The temperature log was requested. The Monthly Refrigeration Temperature Log for the memory care unit dated February 1, 2023, through February 28, 2023, was provided and later reviewed with registered nurse (RN)-B. The refrigerator temperature had been checked 29 out of the 29 opportunities: 13 out of the 28 times the temperature was recorded as being in the acceptable range (36 to 46 degrees Fahrenheit (F). Unacceptable ranges documented were 32.1, 32.6, 32.9, 33.1, 33.3, 34.2, 34.6, 34.9, 35.1, 35.2, 35.7, and 35.9 during the above timeframe. ASSISTED LIVING UNIT On March 6, 2023, at 11:17 a.m., the refrigerator	01880		

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01880	Continued From page 32 was reviewed with ULP-C. ULP-C stated the current temperature was 41 or 42 degrees. The refrigerator contained: - an unopened bottle of latanoprost 0.05% for R10; - an unopened bottle of latanoprost 0.05% for R16; -dose one and dose two of Shirgrix (shingles) vaccine 50 micrograms (mcg)/0.5 milliliters (ml) for R9; and -7 unopened Humalog Kwikpens (fast acting insulin) 100 units/ml and 3 unopened Lantus (long-acting insulin) pens 100 units/ml for R6. On top of the assisted living refrigerator was a temperature log dated March 1, 2023, through March 6, 2023. The refrigerator temperature had been checked 6 out of the 6 opportunities: 0 out of the 6 times the temperature was recorded as being in the acceptable range (36 to 46 degrees (F). Unacceptable ranges documented 32 and 33 five times, during the above timeframe. On March 6, 2023, at approximately 11:25 a.m., RN-B stated she thought the temperatures should be 32 to 36 or 40 degrees. RN-B added night staff takes the refrigerator's temperatures. On March 6, 2023, at 2:37 p.m., RN-B and LALD-A confirmed the RN should be contacted, "or someone" when the refrigerator temperatures are out of range. RN-B and LALD-A added the refrigerator tracking sheets were going to be redone, and they had already spoken to the corporate office about redoing the forms. The manufacturer's instruction for Timolol eye drops dated July 16, 2022, indicated store in an upright position at room temperature, do not freeze, store in a dry place.	01880		

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01880	Continued From page 33 The manufacturer's instructions for latanoprost dated September 16, 2015, indicated store unopened bottles in the refrigerator, between 36 and 46 degrees. Do not freeze. The manufacturer's instructions for Shirgrix dated January 31, 2023, indicated must be stored at refrigerator temperature, between 36 and 46 F. Do not freeze. Vaccine or adjuvant solution that has been frozen must be discarded. The manufacturer's instructions for Humalog Kwikpen insulin dated April 2020, indicated unopened Humalog should be stored in a refrigerator 36-46 degrees F but do not allow to freeze. The manufacturer's instructions for Lantus insulin dated March 2020, indicated unopened Lantus should be stored in a refrigerator 36-46 degrees F. Do not allow Lantus to freeze. Do not put Lantus in a freezer or next to a freezer pack. SECURE MEDICATION STORAGE On March 7, 2023, at 9:05 a.m., the evaluator observed ULP-D prepare R15's morning medication and put R15's oral medication into two medication cups and set the medication cups on top of the medication cart. ULP-D removed a container of diclofenac 1% gel (arthritic pain), anti-itch cream 0.5-0.5% and Vani cream from the medication cart and set them on top of the medication cart. ULP-D removed Gailax (bowel health) from the medication cart and added 17 grams to a cup of water and stirred it up. ULP-D removed a vial of Combient Respimat (nebulizer/chronic obstructive pulmonary disease) and placed it on top of the medication cart. ULP-D pushed the medication cart out of the	01880		

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01880	Continued From page 34 common's area and down a short hallway in which doors were numbered 05, 06, 07, 08 (08 was vacant) and a door titled mechanical room. ULP-D left the medication cart in the hallway with R15's medications unattended. When ULP-D returned to the medication cart she had gloves with her. On March 7, 2023, at 9:14 a.m., ULP-D stated she does "not normally" leave medication unattended. ULP-D added, "I forgot gloves, I had to get some. I wear extra-large gloves and there were none here. I had to get some." On March 7, 2023, at approximately 11:40 a.m., RN-B stated leaving medications unattended was "a big no no." RN-B stated staff should have put the medication back in the medication cart and locked the cart. The licensee's Medication Storage policy revised August 1, 2021, indicated when medications are managed and stored by the facility medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medication. 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	01890		

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01890	Continued From page 35 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 legible information including the opened-on date for time sensitive medication for R6. In addition, licensee failed to monitor for expired medications for R1, R8. 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: On March 6, 2023, at 10:38 a.m., the evaluator toured the facility with licensed assisted living director (LALD)-A, including a review of the locked medication carts in the assisted living and memory units of the facility. LALD-A asked unlicensed personnel (ULP) to review the locked medication carts in the facility with the evaluator. TIME SENSITIVE MEDICATIONS R6 - Lantus 100 units/milligram (ml) insulin pen (one) - Humalog Kwikpen 100 units/ml insulin pen (two) On March 6, 2023, at 10:49 a.m., ULP-C confirmed R6's insulin pens in the assisted living medication cart labeled 1-3 did not have a date	01890		

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01890	Continued From page 36 when opened or when they would expire. The manufacturer's instructions for Lantus insulin pens dated March 2020, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Humalog Kwikpen insulin pens dated April 2020, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. EXPIRED MEDICATION The following medications were found to be expired: - R1's artificial tears expired February 2023 - R8's latanoprost 0.05% expired March 2, 2023 On March 6, 2023, at 11:01 a.m., ULP-D confirmed the medication cart labeled 1 in the memory unit contained expired medication for R1 and R8. On March 6, 2023, at approximately 11:25 a.m., registered nurse (RN)-B stated nursing should have been notified about expired medications. In addition, RN-B added she had asked another licensed staff to look into the expired and undated medications located in the medication carts. The licensee's Medication Storage policy revised August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940	Continued From page 37	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen 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	01940		

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01940	Continued From page 38 be provided on the service plan for one of three residents (R2) receiving 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 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 March 6, 2023, at 9:49 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R2's diagnoses included diabetes and mild cognitive impairment. R2's Service Plan Agreement dated January 9, 2023, did not indicate R2 received treatment or therapy services to include blood glucose (sugar) monitoring. R2's prescriber orders dated December 28, 2022, included blood sugar monitoring twice daily. On March 7, 2023, at 8:29 a.m., the evaluator observed unlicensed personnel (ULP)-E checking R2's blood glucose with R2's blood glucose monitoring device and documented a reading of 170 mg/dl (milligrams per deciliter). R2's Medication Administration Record (MAR)	01940		

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01940	Continued From page 39 dated February 1, 2023, through March 7, 2023, indicated R2's received blood glucose monitoring twice a day. R2's 14-day Uniform Assisted Living Assessment dated January 24, 2023, included scheduled blood sugar checks twice a day. On March 7, 2023, at 8:59 a.m., registered nurse RN-B stated R2 received blood glucose monitoring twice daily and R2's diabetes was currently being managed with medications. RN-B confirmed R2's treatment plan did not include a statement of treatments being provided on R2's service plan to include blood glucose monitoring and stated it should have been indicated on the service plan. The licensee's Treatment and Therapy Management Services policy dated August 1, 2022, indicated each resident receiving management of an orders or prescribed 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF DULUTH	110 COFFEE CREEK BOULEVARD DULUTH, MN 55811

(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
01950	Continued From page 40 delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific written instructions for each resident were documented in three of three resident records (R2, R3, R8) who received therapy or treatment services. 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 March 6, 2023, at 9:43 a.m., licensed assisted living director	01950		

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01950	Continued From page 41 (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R2 R2's diagnoses included diabetes and mild cognitive impairment. R2's record lacked specific written instructions to include parameters for monitoring R2's blood sugar results. R2's prescriber orders dated December 28, 2022, included blood sugar monitoring twice daily. R2's service plan dated January 9, 2023, indicated R2 received services which included medication administration, housekeeping, laundry, assistance with dressing, grooming toileting,and bathing. R2's service plan did not indicate R2 received blood glucose monitoring. R2's 14-day Uniform Assisted Living Assessment dated January 24, 2023, included scheduled blood sugar checks twice a day. R2's Medication Administration Record (MAR) dated February 1, 2023, through March 7, 2023, indicated R2's received blood glucose monitoring twice a day. On March 7, 2023, at 8:29 a.m., the evaluator observed unlicensed personnel (ULP)-E checking R2's blood glucose with R2's blood glucose monitoring device and documented a reading of 170 mg/dl (milligrams per deciliter). ULP-E confirmed R2's record did not include written blood glucose parameters of when to notify the nurse.	01950		

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01950	Continued From page 42 R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung disease), macular degeneration (a condition of the eye which causes vision loss), and high blood pressure R3's record lacked written instructions to include parameters for monitoring R3's oxygen saturation levels (the amount of oxygen in the blood). R3's prescriber orders dated February 15, 2023, included oxygen three (3) liters continuous; however, did not include monitoring oxygen saturation. R3's service plan dated December 5, 2022, indicated R3 received services which included oxygen assist and to check R3's oxygen rate and further instructed to refer to R3's medication administration record (MAR) for specific instructions. R3's February and March 2023 MARs indicted oxygen was set to three (3) liters continuously; however, did not include monitoring R3's oxygen saturation levels and further did not include written specific parameters for R3's oxygen saturation levels. R3's Service Checkoff List indicated the following: -February 2, 2023, O2 saturation of 84%; -February 3, 2023, O2 saturation of 87%; -February 4, 2023, O2 saturation of 86%; -February 8, 2023, O2 saturation of 88%; -March 2, 2023, O2 saturation of 84%; and -March 3, 2023, O2 saturation of 88%. On March 8, 2023, at 8:17 a.m., ULP-L stated R3 required assistance with switching her oxygen	01950		

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01950	Continued From page 43 from the concentrator to portable oxygen tanks, filling the oxygen tanks and checking oxygen levels daily. ULP-L reviewed R3's electronic record and stated she was unable to find parameters set for R3's oxygen saturation levels but would notify the nurse if R3's oxygen level was below 60. On March 8, 2023, at 10:28 a.m., RN-B stated staff should be notifying the nurse when a resident has an oxygen saturation level below 90%. R8 R8's diagnoses include congestive heart failure, hypertension, and mild cognitive impairment. R8's service plan dated January 1, 2023, indicated to take weight daily before food for a diagnosis of congestive heart failure. Take and document client [resident] weight. Community to provide monitoring of client weight as indicated. R8's provider orders dated July 12, 2022, included an order to monitor weights every morning prior to food. On March 7, 2023, at 8:55 a.m., the evaluator observed ULP-D go to a storage closet and get a weight scale. ULP-D asked R8 to go to her room and stand on the scale. ULP-D obtained R8's weight. On March 7, 2023, at 9:19 a.m., ULP-D documented a weight of 174 pounds in R8's electronic record. R8's electronic record failed to include specific written instructions for R8's daily weight to include parameters of when to report R8's weight to	01950		

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01950	Continued From page 44 nursing. On March 8, 2023, at approximately 9:00 a.m., RN-B confirmed the entry in R8's electronic record to take and record R8's weight did not include when staff should report a gain or lost to nursing. Further, RN-B confirmed R2 and R3's records lacked written parameters for R2's blood glucose and R3's oxygen saturation level. The licensee's Physician Orders For Admission (facility standing orders) indicated the appropriate oxygen saturation level was 90% or above and the provider would be notified if oxygen saturation level was out of range. The licensee's Treatment and Therapy Management Services policy revised August 1, 2022, indicated the treatment and therapy management record for each resident would contain; -documentation of specific resident instructions relating to the treatments or therapy administration; and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

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01960	Continued From page 45 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 by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for two of four residents (R8, R14) with health monitoring managed by the provider. 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: R8 R8's diagnoses include congestive heart failure, hypertension, and mild cognitive impairment. R8's service plan dated January 1, 2023, indicated to take weight daily before food for a diagnosis of congestive heart failure. Take and document client [resident] weight. Community to	01960		

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01960	Continued From page 46 provide monitoring of client weight as indicated. R8's provider orders dated July 12, 2022, included an order to monitor weights every morning prior to food. On March 7, 2023, at 7:24 a.m., the evaluator observed R8 sitting at a table in the common's room drinking coffee. On March 7, 2023, at 8:28 a.m., the evaluator observed R8 sitting at a table in the common's room and unlicensed personnel (ULP) asked R8 is she would like a second glass of orange juice and poured orange juice into a glass which was in front of R8. On March 7, 2023, at 8:40 a.m., the evaluator observed a ULP prepare R8's breakfast and set it in front of her. On March 7, 2023, at 8:55 a.m., the evaluator observed ULP-D go to a storage closet and get a weight scale. ULP-D asked R8 to go to her room and stand on the scale. ULP-D obtained R8's weight. On March 7, 2023, at 9:19 a.m., ULP-D documented a weight of 174 pounds in R8's electronic record. ULP-D stated "oh, oh I never saw that before" when she looked R8's electronic record, task scheduled at 7:00 a.m.,"to monitor weights every morning prior to food". On March 7, 2023, at 11:34 a.m., registered nurse (RN)-B confirmed staff should follow instructions when providing monitoring services. R14 R14's diagnoses include heart failure, mild	01960		

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01960	Continued From page 47 cognitive impairment, and orthostatic hypotension (an increase in blood pressure upon assuming an upright posture). R14's service plan dated January 1, 2023, included: -vital sign monitoring daily: blood pressure (BP), pulse, respiration, temperature, and weight; and -medication administration three times daily. R14's medication administration record (MAR) dated March 1, 2023, through March 7, 2023, included: -hydralazine (relaxes blood vessels which then lowers blood pressure) 25 milligram tablet by mouth twice daily. Do not administer for BP less than 140/90; and -additional BP and HR (heart rate) notify nurse if BP is greater than 170 or less than 90. HR greater than 125 or less than 50. On March 7, 2023, at approximately 8:10 a.m., the evaluator observed ULP-C look at R14's MAR and remove a BP cuff from the side of the medication cart. ULP-C took the BP cuff to R14's room and applied the BP cuff to R14's upper right arm. R14's BP, result was 212/92. ULP-C went back to the medication cart and looked at the MAR. ULP-C removed hydralazine 25 mg and gave the medication to R14. On March 7, 2023, at 9:15 a.m., ULP-C commented she would "almost" rather use a manual BP cuff, adding she was not sure if the machines in use worked correctly, adding BP was "high today, crazy high." ULP-C did not contact nursing regarding R14's BP reading. On March 7, 2023, at 11:48 a.m., registered nurse (RN)-B confirmed nursing should have	01960		

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01960	Continued From page 48 been notified about a BP reading of 212/92 and the BP should have been retaken. The licensee's Delegation of Assisted Living Services revised August 1, 2021, indicated a registered nurse or licensed health professional at [name of facility] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. 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: (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 a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property.	02040		

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02040	Continued From page 49 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) 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 of available documentation and interview were conducted March 7, 2023, at approximately 10:15 a.m. with licensed assisted living director (LALD)-A, vice president of policy and compliance (RN)-I, vice president (VP)-J, director of maintenance (DM)-F, director of maintenance (DM)-G and building maintenance and grounds assistant (BMG)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by LALD-A, RN-I, VP-J, DM-F, DM-G and BMG-H during the interview at approximately 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies	02110		

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02110	Continued From page 50 (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 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	02110		

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02110	Continued From page 51 licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, 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 three of three residents (R2, R3, R11). 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 is 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: The facility held an Assisted Living with Dementia Care license for a capacity of 40 residents. R2 R2's diagnoses included diabetes and mild cognitive impairment. R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD-a progressive lung disease), macular degeneration (a condition of the eye which causes vision loss), and high blood pressure R11 R11's diagnoses included down syndrome, dementia without behavioral disturbances and gastro-esophageal reflux disease (GERD).	02110		

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02110	Continued From page 52 R2, R3, and R11's record did not include evidence or documentation the resident or resident's representative had received the policies and procedures related to dementia care as required. On March 7, 2023, at 12:23 p.m., licensed assisted living director (LALD)-A stated the residents and/or resident representatives were verbally told about the dementia care policies at the time of admission. LALD-A stated if families were interested in the policies they would be given access to Educare (online training and education). On March 8, 2023, at 9:37 a.m., vice president of policy and compliance (VPPC)-I stated they had not developed the required dementia care policy regarding limiting the use of public address and intercom systems for emergencies and evacuation drills only. On March 8, 2023, at 10:10 a.m., vice president (VP)-J stated the dementia care policies were not being provided to the residents and thought a statement regarding the dementia care polices was in the Dementia Care Disclosure; however, was not and was going to update the form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=E	144G.91 Subd. 4 (a) 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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ELYSIAN SENIOR HOMES OF DULUTH	110 COFFEE CREEK BOULEVARD DULUTH, MN 55811

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02310	Continued From page 53 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 the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen. 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: On March 7, 2023, at 7:27 a.m., during observations of registered nurse (RN)-B and unlicensed personnel (ULP)-E providing cares and repositioning for R13, the evaluator observed an oxygen cylinder lying on its side in R13's room. RN-B stated R13's oxygen cylinder was not properly stored and further stated oxygen cylinders should be stored in an upright position in a secured holder. On March 7, 2023, at 9:40 a.m. during R3's morning medication pass with ULP-E, the evaluator observed one portable oxygen cylinder against the wall in R3's room, in an upright position, not stored in a holder that was available	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36629	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF DULUTH	110 COFFEE CREEK BOULEVARD DULUTH, MN 55811

(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
02310	Continued From page 54 in R3's room. The licensee's Oxygen policy dated August 1, 2021, noted oxygen cylinders must remain upright at all times and never tip an oxygen cylinder or vessel on its side. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36629	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF DULUTH	110 COFFEE CREEK BOULEVARD DULUTH, MN 55811

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02430	Continued From page 55 failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all fifteen (15) residents residing in the memory care unit. 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 March 7, 2023, at 8:02 a.m., the surveyor observed an opened and unattended lap top computer sitting on a medication cart positioned in the commons area of the memory care unit. The computer screen displayed R11's electronic medication administration record (eMAR). On March 7, 2023, at 8:06 a.m., unlicensed personnel (ULP)-C stated the computer screen was to be closed when not in use, "I do shut it [computer screen] normally, thank you. You make me nervous." ULP-C walked to the medication cart and closed the computer screen. On March 7, 2023, at 8:18 a.m., the evaluator observed ULP-C standing at a medication cart looking at a lap top computer screen which was positioned in the common's area of the memory care unit. ULP-C removed a medication from the cart and placed the medication into a medication cup. ULP-C did not close the lap top computer and R14's eMAR was visible. ULP-C walked towards R14 and told R14 "they" [ULP and R14] needed to go to R14's room. ULP-C and R14	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36629	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02430	Continued From page 56 were nearing R14's room when ULP-C left R14's side and went back to the medication cart. ULP-C stated she "remembered" and closed the lap top computer screen. On March 7, 2023, at 11:30 a.m., registered nurse (RN)-B stated lap top computer screens were to be closed when not in use, resident information should not be visible. The licensee's Resident Record-Confidentiality policy revised August 1, 2021, indicated resident records would be kept confidential and locked in a secure area where only authorized staff of the facility had access to. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *03/06/23*
Time: 11:00:00
Report: 1016231048

Food and Beverage Establishment Inspection Report

Location:
Elysian Senior Homes Of Duluth
110 Coffee Creek Boulevard
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0039385
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184649400
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

A TEST KIT WS NOT AVAILABLE FOR TESTING QUATERNARY AMMONIUM SANITIZER. OBTAIN A TEST KIT FOR QUAT SANITIZER.

Comply By: 03/06/23

Surface and Equipment Sanitizers

Quaternary Ammonia: > 200 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: TOMATOES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: ONIONS
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Type: Full
Date: *03/06/23*
Time: 11:00:00
Report: 1016231048
Elysian Senior Homes Of Duluth

Food and Beverage Establishment Inspection Report

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

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK (RECEIVING KITCHEN)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK (RECEIVING KITCHEN)
Violation Issued: No

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

COMMENTS:

ESTABLISHMENT USES ONLY PASTEURIZED EGGS.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016231048 of 03/06/23.

Certified Food Protection Manager: WADE SCHADEWALD

Certification Number: FM81388 Expires: 12/05/25

Signed: _____
WADE SCHADEWALD
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us