Electronically Delivered

July 29, 2022

Administrator
Good Samaritan Society - Blackduck
152 Margaret Avenue Northwest
Blackduck, MN 56630

RE: Project Number SL30737015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 8, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

**CORRECTION ORDER RECONSIDERATION PROCESS**
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

Free from Maltreatment reconsideration requests should be addressed to:
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,

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30737 | A. BUILDING: _____ B. WING _____ | 07/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - BLACK | 152 MARGARET AVENUE NW BLACKDUCK, MN 56630 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL#30737015<br><br>On, July 5, 2022, through July 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents, all of whom received services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br>The findings include:<br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 5, 2022, for the specific Minnesota Food Code deficiencies.<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |

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| 0 640 | Continued From page 2 | 0 640 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post required content in common area to include posting the 911 emergency number in common area and near telephones provided by the assisted living. This had the potential to affect all 16 residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On July 5, 2022, at approximately 9:55 a.m., during a facility tour, the surveyor did not obverse | 0 640 | | |

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| 0 640 | Continued From page 3<br>911 posted on or near telephones in the commons area as required.<br><br>On July 5, 2022, at 10:25 a.m., licensed assisted living director (LALD)-A and housing manager (HM)-B verified the 911 emergency number was not posted in the commons area or near or on the cordless phone.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 640 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health | 01470 | | |

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| 01470 | Continued From page 4<br><br>Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received orientation to assisted living facility licensing to include all the required topics. | 01470 | | |

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| 01470 | Continued From page 5<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D was hired on February 1, 2022, to provide direct care services to residents at the assisted living facility.<br><br>On July 5, 2022, at 11:40 a.m., the surveyor observed ULP-D monitor R1's blood glucose (sugar) level and administer R1's insulin using a multiple dose pen (device used for insulin administration).<br><br>ULP-'s D employee records lacked the following required orientation content:<br>-an overview of Minnesota's assisted living law;<br>-handing emergencies and using emergency services;<br>-the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights;<br>-consumer advocacy services;<br>-principles of person-centered planning and service delivery and how they apply to direct support services; and<br>-types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure.<br><br>On July 6, 2022, at approximately 3:44 p.m., | 01470 | | |

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| 01470 | Continued From page 6<br>registered nurse (RN)-C confirmed ULP-D had not completed the above noted orientation as required.<br><br>The licensee's Required Training for All Employees-Assisted Living, Minnesota policy reviewed May 13, 2022, indicated all assisted living employees would complete the orientation to assisted living requirements before providing direct care service to resident, to include:<br>- Overview of Chapter 144G;<br>- Introduction and review of Society policies and procedures related to provision of services;<br>- Handling of emergencies and use of emergency procedures;<br>- Assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>- Principles of person-centered planning and service delivery and how they apply to direct support services;<br>- Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints (OHFC);<br>- Consumer Advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>- A review of types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01470 | | |

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| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure services plans were revised to reflect the current services provided for one of two residents (R2) reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a | 01640 | | |

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| 01640 | Continued From page 8<br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's record lacked documentation the service plan was revised each time services were added.<br><br>R2's service plan dated January 20, 2022, indicated R2 received services including medication administration, bathing, grooming, dressing/undressing, toileting, set up assistance with meals, assistance with reorientation/redirection, and vital sign monitoring monthly and as needed.<br><br>R2's prescriber's orders authenticated April 25, 2022, included blood pressure monitoring daily.<br><br>On July 6, 2022, at 10:30 a.m., registered nurse (RN)-C verified R2's service plan did not include daily blood pressure monitoring. RN-C added, "the doctor ordered them once a day, but with reading like that [pointing to a blood pressure tracking sheet] I have staff checking it twice a day."<br><br>The license's Service Agreement-Minnesota policy revised March 2017, indicated when modifications to services were necessary, all pertinent information would be added/deleted/changed, to include:<br>-date;<br>-employee responsible;<br>-the modified service and description of modified service;<br>-frequency of service;<br>-fees associated; and<br>-RN and resident signatures. | 01640 | | |

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| 01640 | Continued From page 9<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01640 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were transcribed as prescribed for one of two residents (R2) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 | 01760 | | |

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| 01760 | Continued From page 10<br>situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's diagnoses included diabetes, hypertension (high blood pressure), Parkinson's (long-term degenerative disorder of the central nervous system that affects the motor system) Lewy body dementia (progressive dementia that leads to a decline in thinking, reasoning, and independent function), enlarged prostate, and depression.<br><br>R2's service plan dated January 20, 2022, indicated R2 received services including medication administration up to six times a day.<br><br>R2's prescriber's orders authenticated April 25, 2022, included metformin (diabetic medication) 500 milligrams (mg) once daily.<br><br>R2's medication administration record (MAR) dated June 1, 2022, through June 30, 2022, included metformin 500 mg by mouth twice a day.<br><br>On July 6, 2022, at 9:30 a.m., registered nurse (RN)-C verified R2's metformin was not transcribed correctly onto the MAR, adding "it is my error, and I will fax the provider."<br><br>The licensee's Medication Administration and Supporting Processes policy reviewed November 1, 2021, indicated the RN or LPN were to transcribe orders from provider to the MAR. The medication was to be written on the MAR exactly as the provider had written the order.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |

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| | 30737 | A. BUILDING: _____ B. WING _____ | 07/08/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY - BLACK | 152 MARGARET AVENUE NW BLACKDUCK, MN 56630 |

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| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to maintain one of one medication refrigerator at an acceptable temperature to ensure medications were stored according to manufacturer's recommendations. In addition, the licensee failed to ensure medication was secured in a locked area. This had the potential to affect all sixteen (16) residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS<br><br>On July 5, 2022, at 1:04 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the contents of the locked medication refrigerator which was in the locked nurse's room. ULP-D confirmed the current temperature of the medication refrigerator was 42 degrees Fahrenheit (F). The following was observed to be | 01880 | | |

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| 01880 | Continued From page 12<br>stored in the medication refrigerator:<br>- one (1) unopened latanoprost 0.05% eye drops (medication to treat high pressure in the eye);<br>- five (5) unopened Novolog 100 units /milliliters (ml) (rapid-acting) insulin pens (a multiple dose pen shaped injector device for insulin administration);<br>-four (4) unopened Victoza 18 milligram (mg)/3 ml (medication used along with diet and exercise to improve blood sugar) pens; and<br>-seven (7) unopened Basaglar 100 units/ml (long-acting) insulin pens.<br><br>The medication refrigerator the log for July was secured to the top of the refrigerator. The surveyor asked for the medication refrigerator logs for May and June 2022.<br><br>The Refrigerator/Freezer Temperature Log for the medication refrigerator dated June 1, 2022, through June 30, 2022, was reviewed with housing manager (HM)-B. The refrigerator temperature had been recorded 21 out of the 30 opportunities; 21 out of the 21 times the temperature was recorded as being in the acceptable range, 36- 46 degrees F. Nine (9) days the temperature had not been recorded.<br><br>On July 5, 2022, housing manager (HM)-B confirmed the temperature of the medication refrigerator had not been checked daily.<br><br>On July 6, 2022, at approximately 10:30 a.m., registered nurse (RN)-C verified staff had not been monitoring the medication refrigerator temperatures as required. RN-C added, "if you knew how many times I have said it needs to be done daily."<br><br>The manufacturer's instructions for latanoprost | 01880 | | |

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|---|---|---|---|---|
| 01880 | Continued From page 13<br>dated September 2015, indicated unopened bottles should be stored in the refrigerator between 36 to 46 degrees F.<br><br>The manufacturer's instructions for Novolog dated June 4, 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze.<br><br>The manufacturer's instructions for Victoza dated June 4, 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze.<br><br>The manufacturer's instructions for Basaglar dated June 4, 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze.<br><br>SECURE MEDICATION STORAGE<br><br>On July 5, 2022, at approximately 11:42, the surveyor observed ULP-C remove R1's Novolog insulin pen, alcohol pad and needle from the medication cart positioned against the wall in the hallway. ULP-C left the medication cart unlocked and knocked on R1's door and entered the room.<br><br>On July 5, 2022, at11:44, directly following this observation ULP-C confirmed the cart was not secured. ULP-C locked the medication cart. ULP-C commented "I forgot; I am nervous."<br><br>On July 5, 2022, at 12:43 p.m., registered nurse (RN)-C confirmed the medication cart should have been locked. RN-C added, "typically they don't take the medication cart out of the medication room, I forgot today myself."<br><br>The Medications Acquisition, Receiving, | 01880 | | |

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| 01880 | Continued From page 14<br><br>Packaging, and Storage policy reviewed October 12, 2021, indicated refrigerators holding medications would have temperatures maintained between 36F and 46 F. The refrigerator temperatures would be checked daily, adjusted as necessary and documented on the Refrigerator/Freezer Temperature Log. In addition, medications would be stored in a locked medication cart. Only the person passing medications and the assisted living community (ALC) nurse would be permitted to have access to the keys to the medication storage areas.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of four residents (R5, R6). In addition the licensee failed to ensure medications labels contained legible information including the expiration date for time sensitive medications for two of four residents (R1, R4).<br><br>This practice resulted in a level two violation (a | 01890 | | |

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| 01890 | Continued From page 15<br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>EXPIRED MEDICATION<br>On July 5, 2022, at 12:56 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the medication cart in the locked nurse's room. The medication cart included:<br><br>R5<br>R5's unopened bottle of Nitroglycerin 0.4 milligrams (mg) (used to treat and prevent chest pain) had expired May 19, 2022.<br><br>R6<br>R6's opened three (3) Systane eye drops (used for dry eye), which had expired respectively on May 1, 2020, April 1, 2021, and May 1, 2021.<br><br>On July 5, 2022, at approximately 1:00 p.m., registered nurse (RN)-C verified the above medications were expired and should have been removed from the medication cart. RN-C, stated "I check it every month, but with the holiday and being short staffed I missed this month, adding "I don't know what happened with those [R6's] eye drops.<br><br>DATING OF TIME SENSITIVE MEDICATIONS<br>On July 5, 2022, at 12:56 p.m., a review of the | 01890 | | |

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| 01890 | Continued From page 16<br>medication cart in the locked nurse's room performed with ULP-D. The medication cart included:<br><br>R1<br>R1's opened Refresh Tears (lubricating eye drops) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire.<br><br>R4<br>R4's two (2) opened bottles of Timolol ophthalmic (eye) 0.25% (used to treat increased pressure in the eye) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire; and opened latanoprost ophthalmic solution 0.005% (glaucoma medication/to treat increased pressure in the eye) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire.<br><br>The manufacturer's instructions for Refresh Tears dated March 2018, directed to discard the eye drop solution 90 days after opening.<br><br>The manufacturer's instructions for Timolol dated October 2019, directed to discard any unused solution after four (4) weeks.<br><br>The manufacturer's instructions for latanoprost dated October 2019, directed to discard any unused solution after four (4) weeks.<br><br>On July 6, 2022, at approximately 3:44 p.m., RN-C confirmed time sensitive medications were to be dated.<br><br>The Medications Acquisition, Receiving, Packaging, and Storage policy reviewed October | 01890 | | |

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| 01890 | Continued From page 17<br>12, 2021, indicated in all assisted living community's (ALC) would routinely check for expired medications. Expired medications would be disposed of in accordance with state pharmacy regulations. In addition, all medications would be labeled according to state pharmacy regulations. Cautionary and accessory instructions as well as the expiration date, would be included.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. | 01910 | | |

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| 01910 | Continued From page 18<br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of all medications to include the medication strength, prescription number, and quantity for all medications for one of one discharged resident (R-3) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>R3 was admitted for services on August 29, 2021, and discharged on May 31, 2022.<br><br>R3's service plan dated August 29, 2021, indicated the resident received medication management services which included medication administration.<br><br>R3's medication administration record (MAR) dated April 2022, included the following medications: levothyroxine (thyroid medication) 50 micrograms (mcg) daily, amlodipine (high blood pressure) 10 milligrams (mg) daily, hydrochlorothiazide (diuretic) 25 mg daily, cetirizine (allergies) 10 mg daily, vitamin B 12 (supplement) 1000 mcg daily, calcium 600/vitamin D 200 (supplement) two tabs daily, vitamin D 3 (supplement) 1000 units daily, vitamin C (supplement) 500 mg daily, lisinopril (cardiac medication) 2.5 mg daily, Trulicity (diabetes) 1.5 | 01910 | | |

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| 01910 | Continued From page 19<br>mg once weekly, metformin (diabetes) 1000 mg twice daily, metoprolol tartrate (cardiac medication) 50 mg twice daily, Advair 250-50 mcg/mcg (asthma) 1 puff twice daily, ferrous sulfate (anemia) 325 mg every other day, Montelukast (asthma) 10 mg daily, and Lipitor (high cholesterol) 80 mg daily.<br><br>R3's prescriber orders dated March 3, 2021, included all of the above noted medications.<br><br>R3's record lacked documentation for the disposition of the medications on R3's MAR.<br><br>On July 5, 2022, at 3:07 p.m., registered nurse (RN)-C verified she did not complete a medication disposition log for R3. RN-C stated R3 went to the skilled nursing facility (SNF) adding all medications were taken there.<br><br>The licensee's Disposition of Medication-Assisted Living policy reviewed October 8, 2021, indicated the disposition of medications would be documented when a resident was discharged or expired to demonstrate that the medications were disposed of according to regulatory requirements.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

Minnesota Department of Health
Food, Pools and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/05/22*
Time: 10:30:20
Report: 1002221117

# Food and Beverage Establishment Inspection Report



**Location:**
Good Samaritan Society - Black
152 Margaret Avenue Nw
Blackduck, MN56630
Beltrami County, 04

**Establishment Info:**
ID #: 0038403
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2188355483
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.

**4-500 Equipment Maintenance and Operation**

4-501.114E ** Priority 1 **

MN Rule 4626.0805E Provide and maintain a chemical sanitizer other than chlorine, iodine or a quaternary ammonium compound according to the US EPA registered label use instructions.

A SPRAY BOTTLE OF SINK & SURFACE WAS MEASURED TO BE 452 PPM WHICH IS LOWER THAN THE REQUIRED MINIMUM ACCORDING TO THE MANUFACTURER'S INSTRUCTIONS. THE SPRAY BOTTLE WAS DUMPED AND REFILLED WITH SANITIZING SOLUTION OF PROPER CONCENTRATION.

*Corrected on Site*

**4-300 Equipment Numbers and Capacities**

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO METHOD AVAILABLE AT TIME OF INSPECTION TO MEASURE THE UTENSIL SURFACE TEMPERATURE OF THE DISH MACHINE. STAFF WERE UNAWARE OF THE REQUIREMENT.

*Comply By: 07/15/22*

**Surface and Equipment Sanitizers**

Acid: = 704 at Degrees Fahrenheit
Location: SINK & SURFACE WIPING CLOTH BUCKET
Violation Issued: No

Acid: = 452 at Degrees Fahrenheit
Location: SINK & SURFACE SPRAY BOTTLE
Violation Issued: Yes

# Food and Beverage Establishment Inspection Report



Hot Water: = at 160 Degrees Fahrenheit
Location: THERMOLABEL - DISH MACHINE
Violation Issued: No

Acid: = 704 at Degrees Fahrenheit
Location: SINK & SURFACE DISPENSER
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: BUTTER - TRAULSEN COOLER
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - TRAULSEN FREEZER
Violation Issued: No

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

Discussion:

Handwashing - fact sheet and sign provided with report

Employee illness - fact sheet, decision guide and log provided with report

Safe cleaning, sanitizing and warewashing - fact sheet provided with report

CFPM - fact sheet and initial application provided with report

Note:
The violation for low sanitizer concentration in the spray bottle does not require a follow up as it was addressed at time of inspection.

**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 1002221117 of 07/05/22.

Certified Food Protection Manager: Kay Kile

Certification Number: FM85920 Expires: 09/22/22

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

Brandon Bjerke
Administrator

Signed: _____

Cassandra Hua
Public Health Sanitarian III
218-308-2142
Cassandra.Hua@state.mn.us