Electronically Delivered

June 4, 2024

Licensee
Lifecare Medical Center
19120 200th Street
Greenbush, MN 56726

RE: Project Number(s) SL27672015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 15, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH 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 based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27672	A. BUILDING: _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	19120 200TH STREET GREENBUSH, MN 56726

(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: SL27672015-0 On May 14, 2024, through May 15, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control related to the use of a biohazard storage container. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 15, 2024, at 7:00 a.m., a red sharps biohazard bin was noted to be stored on R2's kitchen counter next to R2's food preparation area, oven, sink, and refrigerator. Unlicensed personnel (ULP)-B administered R2's insulin injection, removed the needle from the insulin	0 510		

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0 510	Continued From page 2 pen, and then placed the used, contaminated needle in the red sharps biohazard bin on R2's counter. R2 was admitted on September 1, 2021, with the diagnosis of diabetes mellitus and required assistance with insulin injections three (3) times daily by licensee. On May 15, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-D stated R2's biohazard bin should not be stored on R2's counter. CNS-D stated R2's biohazard bin would be considered a contaminated storage receptacle and should be stored below R2's sink to prevent contamination of clean items or R2's counter space. On May 15, 2024, at 9:40 a.m., surveyor returned to R2's room and noted licensee had moved R2's red sharps biohazard bin under R2's sink behind closed doors. The licensee's Sharps policy dated April 4, 2024, failed to indicate a storage location of biohazard sharps containers when stored in a resident's room. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 810		

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0 810	Continued From page 3 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 4 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). The findings include: On May 14, 2024, at 12:30 p.m., maintenance supervisor (MS)-E, and clinical nurse supervisor (CNS)-D, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, failed to include the following: The FSEP did not identify specific fire protection actions for residents evident by not providing documentation of procedures required of residents during a fire or similar emergency. During an interview on May 14, 2024, at 1:00 p.m., MS-E, and CNS-D, stated documentation was not available in writing indicating procedures required of residents during a fire or similar emergency. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the required training was provided to residents annually.	0 810		

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0 810	Continued From page 5 During an interview on May 14, 2024, at 1:05 p.m., MS-E, and CNS-D, stated documentation was not available indicating resident were offered training based on the FSEP procedures at least annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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 licensee'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 potential to affect a large portion or all of the residents).	0 970		

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0 970	Continued From page 6 The findings include: On May 14, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-D provided licensee's blank Resident Agreement and stated document is licensee's assisted living contract used for all residents. Page 14 of the licensee's undated assisted living contract read, "29. Indemnification. As an occupant of the community, you assume the risk for your own safety and for the safety of your personal property... You will indemnify and hold harmless us, our employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by you ... or any other part of the Community, or caused wholly or in part by an act or omission of you..." On May 14, 2024, at 11:30 a.m., CNS-D stated licensee had lawyers draft the contract and licensee was not aware the contract could not include a waiver of liability for the health and safety or personal property of a resident. CNS-D stated the contract would need to be amended to remove the prohibited language. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 7 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500		

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01500	Continued From page 8 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment, for two of two employees (unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired on December 7, 2020, and July 10, 1989, respectively. ULP-A's Training Hours dated May 14, 2024, lacked evidence ULP-A received annual training	01500		

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01500	Continued From page 9 for the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights and a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-B's Training Hours dated May 14, 2024, lacked evidence ULP-B received annual training for the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights and a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On May 15, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-D stated the licensee had recently become aware employees were not being provided all required annual training. CNS-D stated the licensee had developed a plan for ensuring all required content was provided to all employees but had not implemented the plan at the time of the survey and no employee would have all the required annual training. CNS-D stated the licensee had been providing annual training based on the licensee's other nursing home license which lacked state required annual training. The licensee's undated Assisted Living Annual Training policy indicated all appropriate required annual training per statute, but licensee failed to implement the policy. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01880	Continued From page 10	01880		
01880 SS=D	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 medications were stored securely for one of one resident (R2) with medication management 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 15, 2024, at 7:00 a.m., surveyor observed R2's personal refrigerator which included unsecured insulin glargine, insulin aspart, and timolol eye drops. R2 was admitted on September 1, 2021. R2's Attachment D Service Plan Agreement dated September 1, 2021, indicated R2 received Medication Management service and read, "See attached Medications Management Plan."	01880		

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01880	Continued From page 11 R2's Medication Management Assessment - Assisted Living dated April 24, 2024, indicated R2 required assistance with storing and securing medications due to R2's memory impairment and forgetfulness. Additionally, the assessment indicated the storage of medications were, "b. Clients Home - Secured." On May 15, 2024, at 7:00 a.m., unlicensed personnel (ULP)-B stated R2's currently used medications would all be secured in a locked cabinet in R2's room. ULP-B stated R2's overflow insulin and eye drops were stored unsecured in R2's personal refrigerator. On May 15, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-D stated the insulin was stored unsecured in R2's refrigerator as R2 did not have access to needles. CNS-D stated, "it makes sense to lock all those meds up too since we are locking all the other ones up." CNS-D stated the medications would need to be moved to a secured refrigerator in the nursing office to ensure the medications are stored per manufacturer's direction and in a secure location per R2's medication management assessment. The licensee's undated Storage of Medications policy indicated all resident medications would be stored based on the registered nurse's assessment and based on the needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *05/15/24*
Time: 11:00:00
Report: 1002241059

Food and Beverage Establishment Inspection Report

Location:
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN56726
Roseau County, 68

Establishment Info:
ID #: 0038702
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187826138
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: THERMOLABEL - DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: MILK - SATURN COOLER
Violation Issued: No

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

Process/Item: Receiving
Temperature: 160+ Degrees Fahrenheit - Location: CARROTS, SOUP, MEATLOAF, ETC.
Violation Issued: No

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

This assisted living receives three meals a day from the main campus kitchen. The food is transported in a Vulcan hot cart. All leftovers are sent back to the main kitchen.

Discussion:

Handwashing

Employee illness

Safe cleaning, sanitizing and warewashing

Thermometer use/calibration

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 1002241059 of 05/15/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Director
Lifecare Assisted Living

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