Electronically Delivered

June 1, 2022

Administrator
Duluth Heights Lodge Senior Living
724 Maple Grove Road
Duluth, MN 55811

RE: Project Number(s) SL30228016

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 5, 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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL30228016-0 On May 2, 2022, through May 5, 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 61 residents receiving 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. 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for four of nine residents (R1, R3, R6, R9) with records reviewed. This had the potential to affect all 61 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). The findings include:	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 430	Continued From page 2 R1 R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, ted stocking application (compression stockings), housekeeping, and laundry. R3 R3's diagnoses included atrial fibrillation and hypertension. R3's Service Plan dated February 5, 2022, indicated R3 received services which included medication administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and laundry. R6 R6's diagnoses included hypothyroidism (low thyroid level), Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), hypertension (HTN), spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan dated February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, assistance with pressure relief boots, housekeeping, and laundry. R9 R9 moved into the facility on December 1, 2021,	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 430	Continued From page 3 for housing only and received no assisted living services. On May 2, 2022, at 2:32 p.m., licensed assisted living director (LALD)-A stated R1, R3, and R6's records did not include written acknowledgement of receiving the licensee's UDALSA. On May 3, 2022, at 12:43 p.m., LALD-A stated R9's record did not include written acknowledgement of receiving the licensee's UDALSA. The licensee-provided document titled Uniform Checklist Disclosure of Services, undated, indicated the UDALSA must be completed and provided to prospective residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 450	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for four of nine residents (R1, R3, R6, R9) with records reviewed. This had the potential to affect all 61 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). The findings include: R1 R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, indicated R1 required assistance with medication administration, dressing, grooming, bathing, incontinence care, Ted stocking application, housekeeping, and laundry. R3 R3's diagnoses included atrial fibrillation and hypertension. R3's Service Plan dated February 5, 2022, indicated R3 required assistance with medication administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 450	Continued From page 5 laundry. R6 R6's diagnoses included hypothyroidism (low thyroid level), Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), hypertension (HTN), spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan dated February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, assistance with pressure relief boots, housekeeping, and laundry. R9 R9 moved into the facility on December 1, 2021, for housing only and received no assisted living services. On May 2, 2022, at 2:32 p.m., licensed assisted living director (LALD)-A stated R1, R3, and R6's records did not include written acknowledgement of receiving a copy of the Assisted Living Bill of Rights. On May 3, 2022, at 12:43 p.m., LALD-A stated R9's record did not include written acknowledgement of receiving a copy of the Assisted Living Bill of Rights. The licensee-provided policy titled Content of Resident Records dated August 24, 2021, indicated the residents record would contain the assisted living bill of rights and documentation licensee staff reviewed the bill of rights with the resident.	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 450	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 650	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained a current job description for one of three employees (ULP)-C with records reviewed. 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 finding include: ULP-C had a hire date of December 20, 2020, and continued providing services under the new owner's Assisted Living license on December 1, 2021. ULP-C's employee record lacked documented evidence of the following required content: - a current job description, including qualifications, responsibilities and identification of staff persons providing supervision. On May 4, 2022, at 1:55 p.m., licensed assisted living director (LALD)-A confirmed ULP-C's employee record lacked documentation of a job description, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 660 SS=F	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 issued by the Centers for Disease Control and Prevention (CDC) which included ensuring TB training was completed for three of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-C, ULP-D), with records reviewed. 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	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 660	Continued From page 9 of the residents). The findings include: The licensee's Facility Tuberculosis (TB) Risk Assessment dated January 7, 2022, indicated a low risk level. RN-B RN-B had a hire date of March 1, 2021, and continued providing services under the new owners Assisted Living licensee on December 1, 2021. RN-B's employee record lacked documented evidence TB education was completed as required. ULP-C ULP-C had a hire date of December 20, 2020, and continued providing services under the new owner's Assisted Living license on December 1, 2021. ULP-C's employee record lacked documented evidence TB education was completed as required. ULP-E ULP-E had a hire date of October 21, 2020, and continued providing services under the new owner's Assisted Living license on December 1, 2021. ULP-E's employee record lacked documented evidence TB education was completed as required. On May 4, 2022, RN-B confirmed the employee records noted above lacked the required TB	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 660	Continued From page 10 education and training. The licensee-provided policy titled TB Prevention and Control dated August 24, 2021, indicated education would be provided to the assisted living staff regarding TB signs and symptoms. 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 (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 tenant 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.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 680	Continued From page 11 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency disaster plan with all the required content. This had the potential to affect all 61 residents. 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: During the entrance conference on May 2, 2022, at 9:43 a.m., the surveyor made a request to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. The licensee's emergency preparedness (EP) plan lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a thoroughly completed risk assessment; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 680	Continued From page 12 - subsistence needs for staff and residents during an emergency; - evacuation plan; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On May 5, 2022, at 1:36 p.m., licensed assisted living director (LALD)-A verified the emergency preparedness manual had not been fully developed to meet the required content noted above. LALD-A stated she had inquired with other sites to evacuate but had no written agreements in place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 810	Continued From page 13	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 document review and interview, the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 810	Continued From page 14 licensee failed to provide the required plans and training for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 May 2, 2022, at approximately 12:30 p.m., the executive director (ED-A) provided documents for review. Documents were reviewed by survey staff on May 2, 2022, between 12:30 p.m. and 1:10 p.m. 1. The Disaster and Emergency Manual dated 09-29-2021 failed to include the identification of unique or unusual resident needs for movement or evacuation during a fire or similar emergency. 2. The licensee failed to provide the required employee training frequency for fire safety and evacuation. The Disaster and Emergency Manual dated 09-29-2021 stated that employees will be trained on general principles of fire protection upon initial employment and annually thereafter but did not require training at least twice per year after hire. 3. The licensee failed to provide documentation of annual training for residents on the proper actions to take in the event of a fire. Documentation was requested by survey staff but not provided. On May 2, 2022, at approximately 1:15 p.m., the ED-A confirmed during the exit interview that the facility failed to provide the required content within the fire safety and evacuation plans. They also	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 810	Continued From page 15 confirmed that the employee and resident training frequency for fire safety and evacuation was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 900	Continued From page 16 opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of eight residents (R1, R3, R6, R9) with records reviewed. In addition, the licensee had three variations of the contract with a final contract under review. This had the potential to affect all 61 residents. 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, indicated R1 required assistance with medication administration, dressing, grooming, bathing, incontinence care, ted stocking application, housekeeping, and laundry.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 900	Continued From page 17 R3 R3's diagnoses included atrial fibrillation and hypertension. R3's Service Plan dated February 5, 2022, indicated R3 required assistance with medication administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and laundry. R6 R6's diagnoses included chronic obstructive pulmonary disease (COPD), HTN, cerebral vascular disease (stroke), osteoarthritis, and depression. R6's Service Plan dated September 27, 2021, indicated R2 received services which included medication management, laundry, housekeeping, and assistance with bathing. R9 R9 moved into the facility on December 1, 2021, for housing only and received no assisted living services. On May 2, 2022, at 2:32 p.m., licensed assisted living director (LALD)-A stated R1, R3, R6, and R9 all did not have a contract with the new owners of the assisted living license. On May 3, 2022, at 12:15 p.m., LALD-A stated the licensee had three variations of the assisted living contract. LALD-A stated some residents had old contracts from the prior owner and some had contracts with an updated version from the prior owner. LALD-A stated the licensee's recently admitted residents had a contract with the current owner of the assisted living license. LALD-A	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
0 900	Continued From page 18 stated the licensee had a final contract under development and said all residents would receive this contact once finalized. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include background studies for two of four employees (unlicensed personnel (ULP)-C, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01290	Continued From page 19 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 finding include: ULP-C ULP-C had a hire date of December 20, 2020, and continued providing services under the new owner's Assisted Living license on December 1, 2021. ULP-C's employee record lacked documented evidence of the following required content: -background study affiliated under the new license holder. ULP-E ULP-E had a hire date of October 21, 2020, and continued providing services under the new owner's Assisted Living license on December 1, 2021. ULP-E's employee record lacked documented evidence of the following required content: -background study affiliated under the new license holder. On May 4, 2022, at 1:13 p.m., licensed assisted living director (LALD)-A stated both ULP-C and ULP-E had background studies conducted and studies kept in their employee record. LALD-A stated when the prior owner left, they took the employee records which contained the background studies.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01290	Continued From page 20 Verification of Net Study indicated ULP-C and ULP-E both had background studies affiliated with the previous licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing and supervising direct services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee (registered nurse (RN)-B) with records reviewed. 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	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01460	Continued From page 21 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-B was hired on March 1, 2021, and continued providing services under the new owners Assisted Living license on December 1, 2021. RN-B's employee record lacked evidence of completing orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The required training for orientation to assisted living licensing requirements and regulations include the following topics: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01460	Continued From page 22 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 - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On May 4, 2022, at 2:13 p.m., RN-B confirmed she had not completed the orientation to assisted living facility licensing requirements and guidelines. The licensee-provided policy titled Orientation and Annual Training Requirements dated August 24, 2021, indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01620	Continued From page 23 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted reassessment and monitoring following resident's falls for two of six residents (R2, R3) with records reviewed. 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). The findings include: R2 R2's diagnoses included coronary artery disease and atrial fibrillation. R2's assessment dated April 15, 2022, indicated	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01620	Continued From page 24 a fall risk evaluation with a score of 32, high risk for falls. The same assessment indicated R2 walked independently and used a walker. R2's Service Plan dated April 15, 2022, indicated R3 required assistance with mediation administration, dressing reminders, grooming set up, bathing, housekeeping, and laundry. R2's medication administration record (MAR) indicated R2 received scheduled aspirin 81 (milligrams) mg and rivaroxaban (Xarelto) 20 mg, both blood thinners, once daily. R2's incident report dated April 7, 2022, indicated R2 had an unwitnessed fall. R2 was found kneeling on the floor next to his bed without injury. R2 stated he fell out of bed. The same incident report included a section for medical doctor notification, this section left blank. R2's incident report dated April 19, 2022, indicated R2 had an unwitnessed fall. R2 was found next to his bed without injury. R2 stated he rolled of his bed. The same incident report did not indicate R2's medical doctor received notification of the fall. R2's nursing progress notes did not include monitoring after R2's fall on April 7 or 19, 2022. The same progress notes did not include R2's medical doctor received notification of R2's falls. On May 4, 2022, at 2:45 p.m., RN-B stated the licensee's procedure for falls included checking vital signs, check for injury, unlicensed staff alerted the nurse, and filled out an incident report. RN-B stated the nurse would implement a fall intervention. She stated R2 was high risk for falls and verified R2 received scheduled aspirin and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01620	Continued From page 25 Xarelto, blood thinners daily. She stated R2 fell on April 7 and 19, 2022. R3 R3's diagnoses included atrial fibrillation and hypertension. R3's Service Plan dated February 5, 2022, indicated R3 required assistance with mediation administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and laundry. R3's assessment dated February 21, 2022, indicated a fall risk evaluation with a score of 24, moderate risk for falls. The same assessment indicated R2 walked independently and used a walker. R3's MAR indicated R3 received scheduled Eliquis 5 mg twice daily, a blood thinner. R3's incident report dated February 21, 2022, indicated R3 had an unwitnessed fall. R3 was found on the floor without injury. The same incident report included a section for medical doctor notification, this section left blank. R3's nursing progress notes did not include monitoring after R3's fall on February 21, 2022. The same progress notes did not include R3's medical doctor received notification of R3's fall. On May 4, 2022, at 2:45 p.m., RN-B verified R3 received scheduled Eliquis, a blood thinner daily. RN-B stated R3 fell on February 21, 2022. RN-B stated it was an expectation nursing monitored a resident after a fall to include vital sign checks, a head-to-toe assessment, a neurological check, and skin check. RN-B stated nursing should	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01620	Continued From page 26 monitor residents after a fall who took blood thinners. RN-B verified nursing progress notes did not include post fall monitoring for R2 or R3. The licensee-provided policy titled Nursing Assessment dated August 24, 2021, indicated ongoing monitoring and review would be conducted as needed based on changes in the resident's needs. The licensee-provided policy titled Falls Management dated November 1, 2014, indicated after a fall an incident report would be completed, the resident would be placed on alert charting, and the physician would be notified. The licensee-provided policy titled Alert Charting dated November 1, 2014, indicated alert charting would be implemented when a resident's condition required increased monitoring and observation for a limited period of time, until the condition resolved. The same policy indicated a licensed nurse was responsible for alert charting and maintaining it for 72 hours when a resident presents with a condition which included falls. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01640	Continued From page 27 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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was revised to reflect the current services provided for one of six residents (R6), with records reviewed. 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: R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01640	Continued From page 28 chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), hypertension (HTN), spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's hospice verbal orders dated January 6, 2022, included orders to assist in applying pressure relief boots (cushioned boots to relieve pressure from the heels) when R6 was in bed. R6's Service Plan dated February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, housekeeping, and laundry. R6's Evaluation and Service Plan lacked therapy or treatment services to include applying R6's pressure relief moon boots. R6's Individualized Treatment or Therapy Management Plan dated February 24, 2022, indicated pressure relief moon boots were to be applied by the licensee staff at night. R6's Resident Service Plan Caregiver Task Sheet updated February 24, 2022, indicated pressure relieving moon boots were to be applied by the licensee at bedtime. R6's Resident Service Caregiver Task Sign-Off for April 2022, and May 2022, indicated the licensee assisted in applying R6's pressure relieving moon boots at bedtime. On May 3, 2022, at 1:54 p.m., licensed practical nurse (LPN)-G stated R6's pressure relieving boots were applied every night by the licensee after R6 was in bed.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01640	Continued From page 29 On May 3, 2022, at 2:02 p.m., registered nurse (RN)-B stated R6's pressure relieving moon boots were ordered by hospice and were added to R6's caregiver task sheet February 24, 2022. RN-B confirmed R6's Evaluation and Service Plan had not been revised, as required, to include applying R6's pressure relieving moon boots. The licensee-provided policy titled Service Plan Contents dated August 24, 2021, indicated all assisted living residents would have an up- to -date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. In addition, the service plan and revisions would be entered into the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 30 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans included the required content for six of six residents (R1, R2, R3, R5, R6, R7) with records reviewed. 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: R1 R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, indicated R1 required assistance with mediation	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 31 administration, dressing, grooming, bathing, incontinence care, ted stocking application, housekeeping, and laundry. R1's Service Plan lacked the following required content: -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. R2 R2's diagnoses included coronary artery disease and atrial fibrillation. R2's Service Plan dated April 15, 2022, indicated R2 required assistance with mediation administration, dressing reminders, grooming set up, bathing, housekeeping, and laundry. R2's Service Plan lacked the following required content: -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 32 -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. R3 R3's diagnoses included atrial fibrillation and hypertension. R3's Service Plan dated February 5, 2022, indicated R3 required assistance with mediation administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and laundry. R3's Service Plan lacked the following required content: -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. R5 R5's diagnoses included hypertension (HTN), hypothyroidism (low thyroid levels), encephalopathy (brain disease that alters brain function or structure), breast and uterine cancer. R5's Service Plan dated April 4, 2022, indicated R5 received services which included medication management, bathing, housekeeping, and laundry. R5's Service Plan lacked the following required content:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 33 -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. R6 R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), HTN, spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan date February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, housekeeping, and laundry. R6's Service Plan lacked the following required content: -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 34 -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. R7 R7's diagnoses included hypertension (HTN), benign prostatic hyperplasia (BPH) enlarged prostate), urinary retention, and weakness in left leg. R7's Service Plan dated April 18, 2022, indicated R7 received services which included assistance with dressing, housekeeping and laundry. R7's Service Plan lacked the following required content: -the fees for services being provided by the licensee; -the identification of staff or categories of staff who would provide the service; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency that included the action to be taken if the scheduled services cannot be provided; and -the names and contact information of persons the resident wishes to have notified in an emergency or if a significant change. On May 5, 2022, at 1:35 p.m., registered nurse (RN)-B confirmed the same service plan was used for all residents who received assisted living services by the licensee. RN-B further verified the current service plan did not include the above noted required content. The licensee-provided policy titled Service Plan Contents dated August 24, 2021, indicated all assisted living residents would have and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01650	Continued From page 35 up-to-date service plan to include the following: -a description of the services provided; -fees for service; -frequency of each service according to resident assessment and resident preference; -the schedule and methods of monitoring assessments; -the schedule and methods of monitoring staff providing services; -the identification of staff or categories of staff who would provide the service; -a contingency plan to include, the action to be taken by the agency if the scheduled service cannot be provided; -information and method to contact the community; -names and contact information of persons the resident wishes to have notified if there was a significant adverse change in the residents condition; -identification of and information on who has authority to sign for the resident in and emergency; and -circumstances in which the emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional,	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01700	Continued From page 36 or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication management assessments were completed by the registered nurse (RN) to include a review of medications in all required areas for four of five residents (R1, R2, R5, R6) who received medication management services with records reviewed. 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	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01700	Continued From page 37 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 2, 2022, at 9:43 a.m., RN-B confirmed the licensee provided medication management services to the licensee's residents as prescribed. R1, R2, R5, and R6's record lacked evidence the RN conducted a review all medications the resident was known to be taking to include identification of medication use, a review of the side effects, contraindications, and adverse reactions for all prescribed medications. R1 R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, and Individual Medication Management Plan dated February 11, 2022, indicated R1 received medication management services. On May 2, 2022, at 1:55 p.m., the surveyor observed unlicensed personnel (ULP)-D administering R1's scheduled afternoon medications. R2 R2's diagnoses included coronary artery disease and atrial fibrillation. R2's Service Plan and Individual Medication Management Plan dated April 15, 2022, indicated R2 received medication management services.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01700	Continued From page 38 On May 3, 2022, at 8:20 a.m., the surveyor observed licensed practical nurse (LPN)-G administering R2's scheduled morning medications. R5 R5's diagnoses included hypertension (HTN), hypothyroidism (low thyroid levels), encephalopathy (brain disease that alters brain function or structure), breast and uterine cancer. R5's Service Plan and Individual Medication Management Plan dated April 4, 2022, indicated R5 received medication management services. On May 2, 2022, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP)-C administering R5's scheduled afternoon medications. R6 R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), HTN, spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan and Individual Medication Management Plan dated February 24, 2022, indicated R6 received services which included medication management services. On May 2, 2022, at 1:06 p.m., the surveyor observed ULP-C administering R6's scheduled afternoon medications. On May 5, 2022, at 1:35 p.m., RN-B verified the licensee's medication management assessment	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01700	Continued From page 39 and plan did not include indication of medication use, side effects, contraindications, allergic or adverse reactions. RN-B verified the Individual Medication Management Plan included instructions that adverse reactions could be found on the medication administration record (MAR) and stated the licensee's MAR's did not include this. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	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 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 physician orders were transcribed accurately for two of four residents (R5, R6), failed to ensure as needed (PRN) medications had documentation of	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 40 effectiveness after administration for one of four residents (R6), failed to document follow-up procedures when the licensee did not administer medications as prescribed and failed to ensure staff followed procedure for documentation of administered medications for one of four residents (R2) with records reviewed. 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). The findings include: TRANSCRIPTION ERROR R5 R5's diagnoses included hypertension (HTN), hypothyroidism (low thyroid levels), encephalopathy (brain disease that alters brain function or structure), breast and uterine cancer. R5's Service Plan and Individual Medication Management Plan dated April 4, 2022, indicated R5 received medication management services. On May 2, 2022, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP-C) administering medications to R5. R5's physician order dated February 8, 2022, included Chloraseptic throat spray one spray to posterior pharynx (back of throat) three times a day for five days and then three times a day as needed.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 41 R5's April and May 2022, Medication Administration Record (MAR) directed sore throat spray of one spray to posterior pharynx three times daily for five days. R5's April and May MAR did not include prescribed Chloraseptic spray order for continued as needed (PRN) use. R5's physician order dated February 22, 2022, included acetaminophen 325 milligrams (mg) two tablets by mouth three times a day, then three times a day as needed (PRN). R5's physician order dated February 25, 2022, provided direction to discontinue acetaminophen order from February 15, 2022, and administer per orders written on February 22, 2022. R5's April and May 2022, MAR indicated R5 received acetaminophen 500 mg two tablets three times a day for acute tooth pain. R6 R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), HTN, spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan and Individual Medication Management Plan dated February 24, 2022, indicated R6 received services which included medication management services. R6's physician order dated November 7, 2021, included brimonidine 0.1% solution one drop to the left eye twice a day. R6's April and May 2022 MAR directed to place one drop of brimonidine 0.2% solution into both eyes twice a day.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 42	01760		

R6's physician order dated April 29, 2022, included milk of magnesia (MOM) 30 milliliters (ml) by mouth daily as needed for constipation. R6's Medication Administration Record for May 2022, did not include prescribed order for MOM.

On May 2, 2022, at 1:06 p.m., the surveyor observed ULP-C administering medications to R6.

MISSING PRN FOLLOW-UP ON MAR

R6
R6's prescriber orders undated, included the following prn medications:
-hydrocodone/acetaminophen (Norco) 5 mg/325 mg every for hours as needed for pain; and
-Robitussin 20 ml every four hours as needed for cough.

R6's May MAR indicated R6 was administered the following medications:
-Norco for pain 10 times from May 1 to May 3, 2022, and had 9 out of 10 missed opportunities for documenting follow up to determine effectiveness of prn medication administered.
-Robitussin four times from May 1 to May 3, 2022, had two out of four missed opportunities for documenting follow up to determine effectiveness of prn medication administered.

MEDICATION SUPPLY AND ADMINISTRATION DOCUMENTATION

R2
R2's start of services was April 2, 2022.

R2's diagnoses included coronary artery disease and atrial fibrillation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 43 R2's Service Plan and Individual Medication Management Plan dated April 15, 2022, indicated R2 received medication management services. On May 3, 2022, at 8:20 a.m., licensed practical nurse (LPN)-G was observed preparing R2's oral medications and one of R2's scheduled eye drops for morning medication pass. During preparation, LPN-G signed off on the MAR using her initials indicating administered prior to administering medications. During the same observation LPN-G was observed to circle R2's propylene-glycol-glycerin ophthalmic solution (eye drops) on the MAR. The MAR included a written note that indicated "Don't Have yet." LPN-G verified she used her initials for authentication on the MAR prior to administration. She stated this was how she had always documented medication administration on the MAR. LPN-G stated the licensee was waiting on supply of R2's propylene-glycol-glycerin ophthalmic solution and had not received supply since R2 admitted. R2's prescriber orders dated March 10, 2022, indicated orders for propylene-glycol-glycerin ophthalmic solution four times daily. R2's MAR's indicated R2 did not receive scheduled propylene-glycol-glycerin ophthalmic solution four times daily for the month of April or May 2022. R2's progress notes and MAR did not include information related to R2's propylene-glycol-glycerin ophthalmic solution. On May 3, 2022, at 2:02 p.m., registered nurse (RN)-B confirmed R5's Chloraseptic spray and acetaminophen orders were not transcribed	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 44 correctly onto the MAR or administered as prescribed. On May 3, 2022, at 2:25 p.m., RN-B stated R2 did not receive his propylene-glycol-glycerin ophthalmic solution as ordered in April or May 2022. She stated she did not follow-up with R2's medical doctor to inform him the medication ordered was not administered and stated she did not follow-up on R2's medication supply. On May 4, 2022, at 11:21 a.m., RN-B verified R6's MOM order was not transcribed onto May's MAR and confirmed R6's brimonidine eye drop was not being administered as ordered and the order was not transcribed correctly onto R6's April and May 2022, MAR. On May 4, 2022, at 2:45 p.m., RN-B stated it was an expectation staff document on the MAR using initials after medication administration not before. On May 5, 2022, at 1:35 p.m., RN-B stated it was an expectation staff conducted a follow-up on PRN medication effectiveness approximately 30-40 minutes after administration to ensure relief was obtained. The licensee-provided policy titled Documentation of Medication, Treatment, and Therapies dated August 24, 2021, indicated staff would document each task immediately after staff performed the task. The same policy indicated the nurse would document actions to request and obtain needed refills for residents including communications with the prescriber, pharmacy, resident and or resident representative or family. The licensee-provided policy titled PRN Medications dated August 24, 2021, indicated the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01760	Continued From page 45 MAR would include whether staff must check back with the resident following administration to determine whether the PRN was effective, and if so, the length of time after administration when the staff much check in. The licensee-provided policy titled Storage and Handling Medications dated August 24, 2021, indicated the RN would establish a system that addresses how refills and renewals were monitored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01790	Continued From page 46 unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01790	Continued From page 47 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed a written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on May 2, 2022, at 9:43 a.m., registered nurse (RN)-B stated the licensee provided medication management services to residents. The licensee-provided policy titled Leave of Absence Medications dated August 24, 2021, written procedure did not include: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01790	Continued From page 48 have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On May 5, 2022, at 1:35 p.m., RN-B verified the licensee's procedure did not include the above listed content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of six residents (R5, R6) with records reviewed. 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	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01820	Continued From page 49 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 R5's diagnoses included hypertension (HTN), hypothyroidism (low thyroid levels), encephalopathy (brain disease that alters brain function or structure), breast and uterine cancer. R5's Service Plan dated April 4, 2022, indicated R5 received services which included medication management, bathing, housekeeping, and laundry. R5's Medication Administration Record (MAR) for April and May 2022, indicated R5 received fluticasone 50 microgram (mcg) spray two sprays in each nostril once daily as needed, levothyroxine (treats underactive thyroid) 50 mcg one tablet by mouth daily, Losartan (treats high blood pressure) 100 milligrams (mg) one tablet by mouth daily, and oyster shell calcium 500 mg one tablet by mouth daily. On May 3, 2022, at 12:39 p.m., registered nurse (RN)-B confirmed after reviewing R5's record, R5's record lacked signed prescriber orders for the medications noted above. RN-B confirmed all resident records should contain signed prescriber orders and further stated the pharmacy could not supply medications if there were no prescriber orders and planned to contact the pharmacy to request the required orders. R6 R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01820	Continued From page 50 chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), HTN, spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's Service Plan dated February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, housekeeping, and laundry. R6's MAR for April and May 2022, indicated R5 received brimonidine 0.2% solution (lowers pressure in the eye) one drop into both eyes two times a day, lidocaine 5% transdermal patch apply two patches topically to right lateral rib area, and R6 had diclofenac sodium (anti-inflammatory) 1% gel 2 grams to affected areas four times a day as needed. On May 4, 2022, at 11:47 a.m., RN-B confirmed after reviewing R6's record, R6 did not include signed prescribed orders for the medications noted above. The licensee-provided policy titled Content of Resident Records dated August 24, 2021, indicated the residents record would contain orders for prescriptions the licensee managed. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01940	Continued From page 51 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 develop and implement a treatment or therapy management plan for one of three residents (R1) with records reviewed. 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01940	Continued From page 52 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: R1's diagnoses included congestive heart failure and osteoporosis. R1's Service Plan dated February 16, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, ted stocking application (compression stockings), housekeeping, and laundry. R1's Resident Service Care Giver Task sheet dated February 5, 2022, indicated the licensee applied ted stockings in the morning and removed ted stockings in the evening. On May 3, 2022, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-E putting on R1's ted stockings (compression stockings). On May 3, 2022, at 2:55 p.m., registered nurse (RN)-B verified R3's record did not include a treatment and therapy management plan. The licensee-provided policy titled Contents of Resident Records, dated August 24, 2021, indicated resident records would contain an individualized treatment and/or therapy management plan. No further information was provided.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01940	Continued From page 53 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 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 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating treatments, the registered nurse (RN) trained unlicensed personnel (ULP) in the proper methods to perform the treatments for one of one employee (ULP-E) with records reviewed. In addition, the licensee failed to ensure specific written instructions for each resident were documented in two of two resident's records (R3,	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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 54 R6) 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 the entrance conference on May 2, 2022, at 9:43 a.m., RN-B confirmed the licensee provided treatment and therapy services. R3 R3's diagnoses included atrial fibrillation and hypertension. R3's signed service plan dated February 5, 2022, indicated R3 required assistance with mediation administration, dressing and grooming reminders, bathing, leg wrap application, housekeeping, and laundry R3's Individualized Treatment or Therapy Management Plan dated February 21, 2022, indicated ted stockings (compression stockings) and leg wrap application. R3's Resident Service Care Giver Task sheet dated February 5, 2022, indicated the licensee applied ted stockings and leg wraps in the morning and removed ted stockings and leg wraps in the evening.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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 55 R3's Resident Service Caregiver Task Sign Off for April 2022, and May 2022, indicated the licensee assisted with putting on and taking off ted stockings and leg wraps. On May 3, 2022, at 7:24 a.m., ULP-E stated she put on and took off R3's leg wraps. On May 4, 2022, at 2:45 p.m., RN-B stated she did not have written instructions for R3's circaid leg wraps (compression wraps) for unlicensed staff. She stated it was a work in progress and she had been unable to find written instructions. RN-B stated licensed nurses trained the unlicensed staff how to apply the leg wraps. RN-B stated competency testing was not done. R6 R6's diagnoses included hypothyroidism, Crohn's disease (inflammatory bowel disease), back pain, chronic obstructive pulmonary disease (COPD, a condition involving constriction of the airways), hypertension (HTN), spondylosis (degeneration of the spine), cervical lymph node metastasis, thyroid cancer, major depression, and disturbances of emotions. R6's hospice verbal orders dated January 6, 2022, included orders to assist in applying pressure relief boots (cushioned boots to relieve pressure from the heels) when R6 was in bed. R6's Service Plan dated February 24, 2022, indicated R6 received services which included medication management, bathing, transferring, housekeeping, and laundry. R6's Evaluation and Service Plan lacked therapy or treatment services to include applying R6's pressure relief moon boots.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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 56 R6's Individualized Treatment or Therapy Management Plan dated February 24, 2022, indicated pressure relief moon boots were to be applied by the licensee staff at night. R6's Resident Service Plan Caregiver Task Sheet updated February 24, 2022, indicated pressure relieving moon boots were to be applied by the licensee at bedtime. R6's Resident Service Caregiver Task Sign-Off for April 2022, and May 2022, indicated the licensee assisted in applying R6's pressure relieving moon boots at bedtime. On May 4, 2022, at 1:54 p.m., registered nurse (RN)-H confirmed there was no documentation of ULP training and competency tests for applying R6's pressure relieving boots. On May 4, 2022, at 4:03 p.m., RN-B stated R6's pressure relieving moon boots were ordered by hospice and were added to R6's caregiver task sheet February 24, 2022. RN-B confirmed the ULP's were not trained or competency tested for applying R6's pressure relieving moon boots. RN-B further confirmed R6's record lacked specific written instructions for the ULP's to include applying R6's pressure relieving moon boots. The licensee-provided policy titled Delegation of Nursing Tasks, dated August 24, 2021, indicated the RN would verify the ULP was trained and competent to perform delegated tasks and would provide written instructions for performing the procedure to the ULP. No further information was provided.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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 57 TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were current treatment and therapy orders for one of three residents (R1) with records reviewed. 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). The findings include: R1's diagnoses included congestive heart failure. R1's Service Plan dated February 16, 2022, indicated R1 received services which included medication administration, dressing, grooming, bathing, incontinence care, ted stocking	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30228	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULUTH HEIGHTS LODGE SENIOR LIVING	724 MAPLE GROVE ROAD 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
01970	Continued From page 58 application (compression stockings), housekeeping, and laundry. R1's Resident Service Care Giver Task sheet dated February 5, 2022, indicated the licensee applied ted stockings in the morning and removed in the evening. On May 3, 2022, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-E putting on R1's ted stockings. On May 3, 2022, at 2:55 p.m., registered nurse (RN)-B verified R3's record did not include a treatment and therapy management plan. On May 4, 2022, at 8:30 am., RN-B stated she did not have orders for R1's ted stockings in R1's record. RN-B stated she did obtain orders and provided surveyor a copy of orders dated for May 3, 2022. The licensee-provided policy titled Contents of Resident Records, dated August 24, 2021, indicated the resident records would contain orders for treatments or therapy's the licensee managed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *05/02/22*
Time: 11:30:00
Report: 1016221087

Food and Beverage Establishment Inspection Report

Location:
Primrose of Duluth
724 Maple Grove Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0022012
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Primrose Lease Management, LLC

Phone #: 2187244900
ID #: 24033

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

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 191 Degrees Fahrenheit - Location: SQUASH
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: PORK
Violation Issued: No

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

Process/Item: Upright Freezer
Temperature: 37 Degrees Fahrenheit - Location: BLACK BEANS
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 40 Degrees Fahrenheit - Location: COLE SLAW
Violation Issued: No

Type: Full
Date: *05/02/22*
Time: 11:30:00
Report: 1016221087
Primrose of Duluth

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 171 Degrees Fahrenheit - Location: BROCOLLI
Violation Issued: No

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

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

COMMENTS:

ESTABLISHMENT HAS CHANGED NAME TO DULUTH HEIGHTS LODGE SENIOR LIVING

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 1016221087 of 05/02/22.

Certified Food Protection Manager: MICHAEL WALSH

Certification Number: FM51301 Expires: 12/29/24

Signed: _____
MICHAEL WALSH
KITCHEN MANAGER

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

Report #: 1016221087

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
11 East Superior St.
Duluth

No. of RF/PHI Categories Out	0	**Date**	05/02/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Primrose of Duluth	724 Maple Grove Road	Duluth, MN	55811	2187244900

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0022012	Primrose Lease Management, LLC	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/05/22

Inspector (Signature)