Electronically Delivered

November 16, 2023

Licensee
Peterson Colonial Homes 1
4866 Highway 31 North
Brookston, MN 55711

RE: Project Number(s) SL33367015

Dear Licensee:

On November 14, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 18, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: tim.hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

PMB

Electronically Delivered

August 29, 2023

Licensee
Peterson Colonial Homes 1
4866 Highway 31 North
Brookston, MN 55711

RE: Project Number(s) SL33367015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33367	A. BUILDING: _____ B. WING _____	08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 1	4866 HIGHWAY 31 NORTH BROOKSTON, MN 55711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33367015-0 On August 14, 15, and 18, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 13 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was evaluated at twice a year to ensure appropriate staffing levels. This had the potential to affect all 13 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, but was not likely to cause serious injury, impairment, or death), and	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule was last reviewed on August 1, 2021. On August 14, 2023, at 2:32 p.m., licensed assisted living director (LALD)-A stated the licensee's staffing plan has not been reviewed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 3 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 14, 2023, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 4 (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared at least a week in advance and provided to the residents. This had the potential to affect all thirteen (13) 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: On August 14, 2023, at 1:12 p.m., licensed assisted living director (LALD)-A provided a copy of the weekly menu. LALD-A stated the menus were not posted and provided to the residents. LALD-A stated the weekly menus did not include planned menus for all meals. The weekly menu for the week of August 14, 2023, did not include a planned menu for the lunch meal on Wednesday August 16, 2023, Friday August 19, 2023, and Sunday August 21, 2023. In addition, the weekly menu did not include a planned menu for dinner on Tuesday August 15, 2023, Thursday August 17, 2023, and Friday August 18, 2023. No further information was provided.	0 485		

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0 485	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 590 SS=F	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee allowed a staff member, home care director (HCD)-F, to serve as designated representative for two of two residents (R1, R2). 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	0 590		

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0 590	Continued From page 6 affect a large portion or all of the residents). The findings include: R1 R1's diagnoses include schizophrenia, depression, and congestive heart failure (CHF). R1's Resident Agreement for Assisted Living at [name of facility] signed July 14, 2022, indicated HCD-F as R1 designated representative. R2 R2's diagnoses include schizoid-affective disorder, and diabetes. R2's Resident Agreement for Assisted Living at [name of facility] signed July 14, 2022, indicated HCD-F as R1 designated representative. On August 15, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A stated R1 and R2 do not have family so they wanted to put HCD-F as their designated representative. LALD-A was not aware the facility could not be the resident's designated representative. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 590		
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	0 680		

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0 680	Continued From page 7 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) that was reviewed annually and failed to post an emergency preparedness plan prominently. Additionally, the licensee failed to ensure the Missing Persons policy was reviewed annually. This had the potential to affect all thirteen (13) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 8 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 August 14,2023, at 10:00 a.m., the surveyor requested the licensee's EPP, which was later reviewed by the surveyor. During the initial facility tour on August 14, 2023, at approximately 1:00 p.m., during a tour of the facility with licensed assisted living director (LALD)-A, the main entrance and common areas of the facility lacked signage posted or information regarding the licensee's EPP. The licensee's EPP indicated the last review date was August 2021 and was signed by licensed assisted living director (LALD)-A. The Missing Client policy contained in the EPP lacked evidence the policy had been reviewed quarterly, as required. On August 15, 2023, at 2:00 p.m., LALD-A stated the last full review of the EPP was August 2021 and was not aware the Missing Clients policy needed to reviewed quarterly. The licensee's Missing Resident Plan dated August 2021, did not address the need to review the Missing Clients policy quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms on each story	0 780		

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0 780	Continued From page 10 within a dwelling unit and failed to provide interconnected smoke alarms in the dwelling unit. 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 August 17, 2023, between 10:45 a.m. and 11:45 a.m., survey staff toured the facility with the home care director (HCD)-F. During the facility tour, survey staff observed the following: 1. When HCD-F tested the smoke alarms in resident sleeping rooms, these smoke alarms did not activate any of the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. 2. A smoke alarm was not installed in the basement. During the facility tour interview, HCD-F explained that a smoke detector was provided in the basement and confirmed that a smoke alarm was not installed. HCD-F confirmed that smoke alarms were not interconnected so that actuation of one alarm would cause all alarms in the dwelling unit to operate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 780		

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0 780	Continued From page 11 (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 August 17, 2023, between 10:45 a.m. and 11:45 a.m., survey staff toured the facility with the home care director (HCD)-F. During the facility tour, survey staff observed the following:	0 800		

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0 800	Continued From page 12 1. Annual inspections were not being completed on the fire sprinkler system. The inspection tag on the fire sprinkler system was dated 2015. 2. Annual inspections were not being completed on the automatic fire alarm system. The last recorded inspection date on the fire alarm panel was 2017 and the inspection tag attached to the panel showed that the system was non-compliant. 3. One exit sign was not illuminated on the second story. "Bad Fixture" was written on the inspection tag dated January 2023. 4. Two emergency lights did not work when tested, one in the main floor living room and the other outside resident room 8. 5. In the smoking room, duct tape covered the wall timer. The electrical box for the timer was observed to be loose under the duct tape. Additionally, there was a hole in the wall. 6. There was a broken floor tile that was observed to be loose at the base of the stairs on the main floor. Wall tiles were missing in the hall outside the bathroom on the main floor. 7. One ceiling tile was missing in the office. One ceiling tile was missing in the linen closet. Several ceiling tiles were water-stained in the dining room. The HCD-F explained during the tour that there had been a water leak on the second story which damaged the dining room ceiling tiles. 8. Electrical panels were obstructed in the linen closet and a utility closet on the main floor. 9. A septic tank cover was loose with only one screw securely fastened in the backyard. 10. Burnt used cigarettes were observed being disposed of outside the building in tin cans and directly on deck surfaces. Additionally, burnt used cigarettes were observed in a cup of water and on the floor in resident room 16, creating a potential fire hazard. The HCD-F explained that listed disposal containers for cigarettes had	0 800		

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	33367	A. BUILDING: _____ B. WING _____	08/18/2023

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0 800	Continued From page 13 already been purchased and would be used. These deficient conditions were verified by HCD-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 14 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to complete the required employee evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 August 17, 2023, at approximately 11:45 a.m., documents were provided by the home care director (HCD)-F. Survey staff requested evacuation drill records. HCD-F explained that the licensed assisted living director (LALD)-A had those files stored electronically and confirmed that these records were not available for review. HCD-F stated that they would have the LALD-A email these drill records once they returned to the facility later that day. The LALD-A emailed fire drill and EPP drill evacuation records on August 17, 2023, at 1:51 p.m. to survey staff. The licensee failed to meet the required evacuation drill frequency. Evacuation drill records for 2023 were dated 5/17/2023 and	0 810		

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0 810	Continued From page 15 3/15/2023. The evacuation drill frequency of twice per year per shift with at least one evacuation drill every other month was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 16 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative to one of one resident (R2). 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: R2's diagnosis included schizoid-affective disorder and diabetes. R2's service plan dated August 12, 2022, indicated R1 received assistance with medication management, bathing, dressing, grooming, laundry, housekeeping, and blood glucose	01060		

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01060	Continued From page 17 monitoring. R2's Progress Notes dated July 12, 2023, at 10:49 a.m., indicated R2 was shaky and weak this morning with an evaluated blood sugar, blood pressure, and pulse. The ambulance was called and the resident was taken to the hospital. On July 14, 2023, R2 returned from the hospital. R2's record lacked evidence the resident, legal representative, or designated representative had been provided the emergency relocation notice. On August 15, 2023, at 9:30 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the need to provide the emergency relocation notice to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 18 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 ULP (ULP)-E followed RN (registered nurse) written instructions for the administration of inhalers and the licensee failed to ensure medications were administered as ordered for one of two residents (R2). 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: ULP-E INHALER ADMINISTRATION R1's diagnoses included schizophrenia and congestive heart failure (CHF). R1's service plan date August 12, 2022, indicated R1 received assistance with medication administration. On August 15, 2023, at 8:00 a.m., the surveyor observed ULP-E administer R1's morning medications. ULP-E handed R1 his Incruse Ellipta inhaler. R1 administered one puff of the inhaler. ULP-E did not instruct R1 to swish R1's mouth with water after using the inhaler. ULP-E stated she did not instruct R1 to swish R1's	01760		

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01760	Continued From page 19 mouth with water after using the inhaler. R1's August 2023 medication administration record (MAR) indicated Incruse Ellipta, inhale one puff once daily. Swish with water and spit after each use. R2 R2's diagnoses included schizoid-affective disorder and diabetes. R2's service plan dated August 12, 2022, indicated R2 received assistance with medication management, bathing, dressing, grooming, laundry, housekeeping, and blood glucose monitoring. R2's prescriber's orders dated May 24, 2023, included the following: Novolog insulin 10 units three times a day with meals. In addition, insulin to treat high blood glucose, use the following sliding scale: less than 160= no extra; 161-190 = 1 unit; 191-220 = 2 units; 210-250 = 3 units; 250-280 = 4 units; 281-310 = 5 units; 311-340 = 6 units; 341-370 = 7 units; 371-400 = 8 units; and greater than 400 = 9 units. R2's vital sign record indicated R2's blood glucose readings in July 2023 at 8:00 a.m. ranged from 171 to 378. R2's July 2023 MAR lacked the number of units of sliding scale Novolog insulin R2 received at 8:00 a.m. on July 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, and 31, 2023. R2's vital sign record indicated R2's blood glucose readings in July 2023 at 12:00 p.m. ranged from 209 to 409.	01760		

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01760	Continued From page 20 R2's July 2023, MAR lacked the number of units of sliding scale Novolog insulin R2 received at 12:00 p.m. on July 2, 4, 5, 6, 7, 8, 9, 11, 15, 18, 19, 20, 21, 23, 26, 27, 28, and 29, 2023. R2's July 2023, MAR lacked evidence R2 received Novolog 10 units at 12:00 p.m. on July 8, 9, 18, 20, and 29, 2023. R2's vital sign record indicated R2's blood glucose readings in July 2023 at 5:00 p.m. ranged from 173 to 580. R2's July MAR lacked the number of units of sliding scale Novolog insulin R2 received at 5:00 p.m. on July 2, 3, 4, 7, 24, and 31, 2023. R2's vital sign record indicated R2's blood glucose readings in July 2023 at 8:00 p.m. ranged from 223 to 512. R2's July MAR lacked the number of units of sliding scale Novolog insulin R2 received at 8:0 p.m. on July 2, 3, 4, 5, 6, 7, 8, 9, 11, 21, 23, 24, and 31, 2023/ R2's vital sign record indicated R2's blood glucose readings in August 2023 at 8:00 a.m. ranged from 195 to 366. R2's August 2023 MAR lacked the number of units of sliding scale Novolog insulin R2 received at 8: 00 a.m. on August 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, and 14, 2023. R2's vital sign record indicated R2's blood glucose readings in August 2023 at 12:00 p.m. ranged from 246 to 398. R2's August 2023 MAR lacked the number of units of sliding scale Novolog insulin R2 received at 12:00 p.m. on August 2, 5, 11, and 12, 2023. R2's vital sign record indicated R2's blood glucose readings in August 2023 at 5:00 p.m.	01760		

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01760	Continued From page 21 ranged from 220 to 398. R2's August 2023 MAR lacked the number of units of sliding scale Novolog insulin R2 received at 5:00 p.m. on August 4, 2023. R2's vital sign record indicted R2's blood glucose readings in August 2023 at 8:00 p.m. ranged from 222 to 398. R2's August 2023 MAR lacked the number of units of sliding scale Novolog insulin R2 received at 8:00 p.m. at 8:00 p.m. on August 2, 4, 7, and 12, 2023. On August 15, 2023, at 10:10 a.m., clinical nurse supervisor (CNS)-B stated R2's July and August 2023 MAR's lacked documentation of the number of units of sliding scale Novolog insulin R2 received as indicated above. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 7, 20222, indicated ULP that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN may administer medications by following the RN's written instructions for administering the medications to the resident. The licensee's documentation of Medications, Treatment and Therapy Management Services policy dated July 7, 2022, indicated RNs, LPNs (licensed practical nurse), and ULPs will appropriately document all medications, treatments, and therapy management services provided to residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 22 days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications included the open and expiration date for time sensitive medications for two of two resident (R1, R4) with records reviewed. In addition, one of one residents inhalers lacked the original prescription label (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 15, 2023, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-E remove R4's Novolog insulin pen from the locked medication cart. R1's Novolog insulin pen was not	01890		

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01890	Continued From page 23 dated with the date the Novolog Flexpen was opened or the expiration date. ULP-E stated R4's Novolog Flexpen was not marked with the open or expiration date. ULP-E stated they were supposed to date the Novolog Flexpen with the open and expiration date. On August 15, 2023, at 8:00 a.m., the surveyor observed ULP-E administer R1's morning medications. R1's Incruse Ellipta and Breo Ellipta inhalers contained the original pharmacy label but did not include the date when the inhaler was opened or when the inhaler expired. R1's Albuterol inhaler was stored in a zip lock bag that did not contain the original pharmacy label. ULP-E stated R1's inhalers did not contain the date when the inhaler was opened or the expiration date. In addition, ULP-E stated R1's Albuterol inhaler did not contain the original pharmacy label. On August 15, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated ULPs had been trained to date the insulin pens when open and to put the expiration date on the insulin pens. CNS-B stated inhalers were to be marked with opened date and expiration date and kept in the inhaler box with the original pharmacy container. Novolog Flexpen FDA (Federal Drug Administration) guidelines dated February 2015, indicated opened Novolog Flexpen should discarded after 28 days. Breo Ellipta inhaler FDA guidelines dated January 2019, indicated discard Breo Ellipta six (6) weeks after opening the foil tray or when the counter reads "0". Incruse Ellipta inhaler FDA Guidelines dated	01890		

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01890	Continued From page 24 February 2016, indicated discard Incruse Ellipta six (6) weeks after opening the foil tray or when the counter reads "0". The licensee's Storage of Medication policy dated August 1, 2021, indicated medications will kept in its original container bearing the original prescription label and stored according to manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *08/14/23*
Time: 10:40:00
Report: 7983231129

Food and Beverage Establishment Inspection Report

Location:
Peterson Colonial Homes 1
4866 Highway 31 North
Brookston, MN55711
St. Louis County, 69

Establishment Info:
ID #: 0038743
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184535646
ID #:

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

The following orders were issued during this inspection.

5-400 Sewage

5-402.13 ***** Priority 1 *****

MN Rule 4626.1200 Sewage, including liquid waste, must be conveyed to the point of disposal through an approved sanitary sewage system.

ONE SEWAGE TANK COVER WAS NOT SECURED. PLEASE PROVIDE EVIDENCE THAT THE COVER HAS BEEN SECURED.

Comply By: 08/21/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.115AB ***** Priority 2 *****

MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.

THE CAT ENTERED THE KITCHEN TWICE DURING THE INSPECTION. TAKE MEASURES TO PREVENT THE CAT FROM ENTERING THE KITCHEN.

Comply By: 08/14/23

Food and Equipment Temperatures

Process/Item: Upright Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Raw shell egg in the Beverage Air double-door upright refrigertor.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 7 Degrees Fahrenheit - Location: Food in the left Frigidaire single-door upright freezer was frozen solid.
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the right Frigidaire single-door upright freezer was frozen solid.
Violation Issued: No

Process/Item: Chest Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Frigidaire chest freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Butter in the refrigerator compartment of the Whirlpool refrigerator/freezer.
Violation Issued: No

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

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GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Provide evidence that the sewage tank cover has been secured.

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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 7983231129 of 08/14/23.

Certified Food Protection Manager: Julie Knochenmus

Certification Number: FM28196 Expires: 02/01/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tammy Couture
Person in Charge

Signed: 7983

651-201-4500
health.foodlodging@state.mn.us