DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 5, 2022

Administrator
Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN 55711

RE: Project Number(s) SL33366015

Dear Administrator:

On September 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 13, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica 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
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Electronically Delivered

July 29, 2022

Administrator
Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN 55711

RE: Project Number SL33366015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 13, 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
5 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
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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 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: SL#33366015 On July 11, 2022, through July 13, 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 23 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 11, 2022, at approximately 9:30 a.m., upon entrance, LALD-A indicated he was the LALD for the facility. LALD-C obtained an assisted living director license on July 7, 2022. On June 11, 2022, at 8:00 a.m., the BELTSS website indicated LALD-A held a current assisted living director license. The BELTSS website did not identify LALD-A as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On June 11, 2022, at approximately 9:30 a.m., LALD-A acknowledged he was not listed as the Director of Record for the licensee. LALD-A stated he was not aware of the requirement for the Director of Record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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; This MN Requirement is not met as evidenced by: Based on observation, 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 three of three resident (R1, R2, and R3) with records reviewed. This had the potential to affect all residents.	0 450		

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0 450	Continued From page 3 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had a current assisted living license. On July 12, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R1's morning medications. R1 R1's record included a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. R2 On July 12, 2022, at approximately 8:00 a.m., the surveyor observed ULP-F administer R2's morning medications. R2's record included a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. R3 On July 12, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F administer R2's morning medications. R3's record included a copy of the Minnesota Home Care Bill of Rights for Assisted Living	0 450		

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0 450	Continued From page 4 Clients of Licensed Only Home Care Providers dated November 2019. On July 12, 2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B both confirmed R1, R2, R3, and all other residents receiving services under their Assisted Living licensee have not received the Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021. The licensee's Notice of Resident Rights policy, dated August 11, 2021, indicated a written acknowledgement of the residents' receipt of the Assisted Living Bill of Rights will be obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance	0 460		

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0 460	Continued From page 5 notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 23 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 11, 2022, at approximately 9:30 a.m., the licensed assisted living director (LALD)-A stated the facility did not provide a means for residents to request assistance. LALD-A stated the residents at times would use their cell phones to call staff. During the initial tour of the facility with LALD-A on July 11, 2022, at approximately 1:00 p.m., the surveyor observed the facility was a three-story building with the office, kitchen, dining room, living room, bathroom and 14 bedrooms on the first floor; nine (9) bed rooms, bathroom, and lounge on the second floor, and an office on the	0 460		

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0 460	Continued From page 6 third floor. The current census was 23. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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	0 470		

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0 470	Continued From page 7 by: Based on interview and record review, the licensee failed to ensure the staffing plan was developed, potentially affecting all twenty-three (23) residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit; and staff experience, training, and competency. On July 11, 2022, during the entrance conference at 9:30 a.m., licensed assisted living director (LALD)-A stated they had a staffing plan policy and they post the daily staffing schedule.	0 470		

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0 470	Continued From page 8 On July 12, 2022, at approximately 2:00 p.m., LALD-A and registered nurse (RN)-B both confirmed a staffing plan had not been developed. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated August 12, 2021, indicated the clinical nurse supervisor will develop, write and implement a staffing plan. 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: (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: (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:	0 480		

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0 480	Continued From page 9 Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 11, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 10 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reusable medical equipment was disinfected between 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 12, 2022, at approximately 9:10 a.m., the surveyor observed ULP-F perform blood pressure monitoring on R1 using an automatic blood pressure machine. ULP-F applied the blood pressure cuff to R1's. ULP-F removed the blood pressure cuff from R1 right arm and placed the automatic blood pressure machine back into the zippered case. ULP-F did not disinfect the blood pressure cuff after using. ULP-F confirmed she did not disinfect the blood pressure cuff after using and before place the automatic blood pressure machine back into the zippered case. On July 12, 2022, at approximately 2:00 p.m. registered nurse (RN)-B stated ULP-F should have disinfected the blood pressure cuff before placing the automatic blood pressure machine back in the zippered case.	0 510		

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0 510	Continued From page 11 The licensee's Disinfecting Reusable Equipment policy dated August 12, 2021, indicated reusable equipment is to be disinfected after each use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. 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 July 11, 2022, at approximately 9:30 a.m., upon entering the building, the facility's license was not displayed or posted at or near the main entrance as required. The surveyor observed the	0 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
0 570	Continued From page 12 license posted outside the nursing office. On July 11, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-C confirmed the facility's license was not posted at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 730	Continued From page 13 resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for three of three residents (R1, R2, and 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, 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).	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 730	Continued From page 14 The findings include: R1 R1's Service Plan dated August 5, 2021, indicated services included medication administration, activity assistance two times a day, ambulation three times a day, bathing two times a week, dressing assistance two times a day, grooming assistance two times a day, housekeeping daily, laundry daily, and linen change weekly. R1's Service Delivery Record for June 2022, indicated the unlicensed personnel (ULP) documented the services as follows: -activity assistance fifteen (15) out of 30 opportunities; -ambulation thirty-four (34) out of 90 opportunities; -bathing four (4) out of eight (8) opportunities; -dressing fifty-three (53) out of sixty (60) opportunities; -grooming seventeen (17) out of sixty (60) opportunities; -housekeeping fifteen (15) out of thirty (30) opportunities; and -laundry one (1) of four (4) opportunities. R1's Service Delivery Record for July 2022, indicated the ULP documented the services as follows: -activity assistance nine (9) out of eleven (11) opportunities; -ambulation eighteen (18) out of thirty-three (33) opportunities; and -grooming nineteen (19) out of twenty-two (22) opportunities. R2	0 730		

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0 730	Continued From page 15 R2's Service Plan dated August 5, 2021, indicated services included medication administration, catheter care reminders three times a day, grooming two times a day, housekeeping daily, and laundry daily. R2's Service Delivery Record for June 2022, indicated the ULP documented the services as follows: -grooming forty-nine (49) out of sixty (60) opportunities; -housekeeping twelve (12) out of thirty (30) opportunities; and -laundry two (2) out of four (4) opportunities. R2's Service Delivery Record for July 2022, indicated the ULP documented the services as follows: -grooming nineteen (19) out of thirty (30) opportunities; and -housekeeping nine (9) out of eleven (11) opportunities. R3 R3's Service Plan dated June 28, 2022, indicated services included medication administration, daily bathing, activity assistance daily, grooming, daily, housekeeping daily, laundry daily, and linen change weekly. R3's Service Delivery Record for June 2022, indicated the ULP documented the services as follows: -bathing twenty-seven (27) out of three (3) opportunities; -activity assistance seventeen (17) out of thirty (30) opportunities; -grooming twenty-five (25) out of thirty (30) opportunities; -housekeeping twelve (12) out of thirty (30)	0 730		

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	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 16 opportunities; -laundry nine (9) out of thirty (30) opportunities; and -linen change three (3) out of four (4) opportunities. On July 12, 2022, at approximately 2:00 p.m., registered nurse (RN)-B confirmed R1, R2, and R3's services were not documented as indicated above. RN-B stated she had been addressing the need for documenting services provided and every staff meeting. The licensee's Resident Records policy dated August 12, 2021, indicated the resident record will contain documentation that services have been provided according as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 780		

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0 780	Continued From page 17 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 that complied with fire protection requirements. 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 July 12, 2022, between 10:15 a.m. and 12:05 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed an empty smoke alarm bracket on the ceiling in room 24. A smoke alarm was not installed in room 24. During the tour interview, the LALD-A explained that room 24 was currently being used for storage and confirmed that the smoke alarm was missing. No further information was provided.	0 780		

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0 780	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (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 July 12, 2022, between 10:15 a.m. and 12:05 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. Several fire sprinkler heads had been painted	0 800		

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0 800	Continued From page 19	0 800		

or had paint on sprinkler components.
2. The fire sprinkler inspection tag was dated 03-18-2020.
3. Water was noted on the floor in the basement and water damage was noted on some of the wall surfaces.
4. In the basement, two light switches and one outlet were missing covers.
5. Several bathroom vent covers were dusty.
6. The ceiling had been patched in one of the shower stalls but not painted or finished to seal the surface.
7. There was a hole in the wall in the lounge with the TV on the main floor.
8. One window was cracked above the air conditioner in a resident apartment as observed from the exterior tour of the building.
9. The bathroom on the second floor was not provided with an exhaust fan and a screen was not installed on the window. This bathroom was noted as being very warm and humid.
10. The fan was dusty in the smoking room.

During the tour interview, the LALD-A confirmed that these items required maintenance.

11. On the second floor deck, a propane griddle had been placed on a wood table which was positioned adjacent to the wood deck railing.
12. Cigarette butts were observed in a tin can filled with water on the deck floor.

During the tour interview, the LALD-A confirmed that the propane griddle required removal and that cigarette butts should not be disposed of in this location.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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0 800	Continued From page 20 (21) days	0 800		
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 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	0 900		

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0 900	Continued From page 21 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 assisted living contract with the required content for three of three residents (R1, R2, and R3) with records reviewed. This had the potential to affect all 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: R1, R2, and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (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 In addition, R1, R2, and R3's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents	0 900		

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0 900	Continued From page 22 and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. R1 R1's Service Plan dated August 5, 2021, indicated services included medication administration, activity assistance two times a day, ambulation three times a day, bathing two times a week, dressing assistance two times a day, grooming assistance two times a day, housekeeping daily, laundry daily, and linen change weekly. R2 R2's Service Plan dated August 5, 2021, indicated services included medication administration, catheter care reminders three times a day, grooming two times a day, housekeeping daily, and laundry daily. R3 R3's Service Plan dated June 28, 2022, indicated services included medication administration, daily bathing, activity assistance daily, grooming, daily, housekeeping daily, laundry daily, and linen change weekly. On July 12, 2022, at approximately 2:00 p.m., registered nurse (RN)-B provided a copy of the licensee's Assisted Living Contract. RN-B stated R1, R2, and R3 and all other residents receiving services under the licensee's Assisted Living licensee were given a copy of the Assisted Living Contract to read and the residents signed the signature sheet of the contract. RN-B stated only the signature sheet was placed in the resident's	0 900		

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0 900	Continued From page 23 record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=D	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 observation, interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of two employees (unlicensed personnel (ULP)-G) 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	01290		

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01290	Continued From page 24 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: ULP-G was hired on October 4, 2021, to provide direct care services under the licensee's Assisted Living license. On July 12, 2022, throughout the survey, the surveyor observed ULP-G provide direct care services to several residents. ULP-G employee record contained a background study that was not affiliated with the licensee's Assisted Living license. The background study was affiliated with another licensee owned by the same owner. On July 13, 2022, at approximate 10:30 a.m., licensed assisted living director (LALD)-A stated ULP-G worked at the owner's other facility that also has an assisted living license. ULP-G was brought over to this facility to provide direct care services. LALD-A confirmed the background study in ULP-G record was not affiliated with the assisted living license. The licensee's Background Checks policy dated August 11, 2021, indicated all employees with direct care contact will undergo a background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of two unlicensed personnel (ULP)-F who performed blood pressure monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01420		

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01420	Continued From page 26 ULP-F On July 12, 2022, at approximately 9:10 a.m., the surveyor observed ULP-F perform blood pressure monitoring on R1 using an automatic blood pressure machine. ULP-F applied the blood pressure cuff to R1's. ULP-F removed the blood pressure cuff from R1 right arm and placed the automatic blood pressure machine back into the zippered case. ULP-F did not disinfect the blood pressure cuff after using. ULP-F's employee record indicated on September 27, 2018, ULP-F had been trained and demonstrated competency using a manual blood pressure machine using a stethoscope. On July 13, 2022, at approximately 10:30 a.m., home care director (HCD)-E confirmed ULP-F's employee record lacked documentation to indicate the RN had conducted training and competency evaluation on the automatic blood pressure machine. The licensee's Delegated Nursing Task policy dated August 11, 2021, indicated the RN will verity the ULP is trained and competent and is instructed in the proper methods to perform the delegated task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services	01460		

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01460	Continued From page 27 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 observation, interview, and record review, the licensee failed to ensure staff providing direct services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (unlicensed personnel/ULP-F and ULP-G) 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: ULP-F ULP-F started employment on June 14, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On July 12, 2022, at approximately 9:00 a.m. the surveyor observed ULP-F administer R1's morning medications.	01460		

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01460	Continued From page 28 ULP-G ULP-G was hired on October 4, 2021, to provide direct care services under the licensee's assisted living license. On July 12, 2022, throughout the day, the surveyor observed ULP-G provide direct care services to several residents. ULP-F and ULP-G's employee records lacked documentation to indicate the ULP had completed orientation to assisted living facility licensing requirements and regulations. On July 13, 2022, at approximately 10:30 a.m., home care director (HCD)-E confirmed ULP-F and ULP-G had not completed orientation to assisted living facility licensing requirements and regulations. The licensee's Assisted Living Orientation policy, dated August 11, 2021, indicated unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01790 SS=D	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	01790		

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01790	Continued From page 29 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 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;	01790		

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01790	Continued From page 30 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-D, ULP-E) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all seven (7) 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 11, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee	01790		

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provided medication management services to the 22 resident at the facility, and the ULP would prepare and send medications with the residents for unplanned times away.

ULP-F
ULP-F started employment on June 14, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On July 12, 2022, at approximately 9:00 a.m. the surveyor observed ULP-F administer R1's morning medications.

ULP-G
ULP-G was hired on October 4, 2021, to provide direct care services under the licensee's assisted living license.

R1's June 2022 medication administration record indicated ULP-G administered medications to R1.

ULP-F and ULP-G's employee record lacked evidence to indicate they had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home.

On July 13, 2022, at approximately 10:30 a.m., home care director (HCD)-E confirmed ULP-F and ULP-G's employee record lacked documentation to indicate ULP-F and ULP-G had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home.

The licensee's Medications for a Client Who Will Be Away From Home policy, dated August 11, 2021, indicated the RN my delegate this task to

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01790	Continued From page 32 ULP if the RN has trained and competency tested the ULP on Procedures to follow when giving medications to clients who will be away from home when medications are scheduled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure medications were securely stored. This had potential to affect all residents and facility 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 July 111, 2022, at approximately 12:10 p.m., the surveyor observed the following medications sitting on the counter in staff bathroom:	01880		

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01880	Continued From page 33 -R1's Albuteral solution 2.5 mg (milligrams)/ 3 ml (mililiters) (nine (9) ampoules); -R4's Budesonide 0.5 mg/2 ml (three packages containing five (5) ampoules each); and -R4's Ipratropium bromide and Albuteral sulfate (twenty-five (25) ampoules). On July 11, 2022, at approximately 12:15 p.m., unlicensed personal (ULP)-F stated the medications have been stored in the staff bathroom for years. On July 11, 2022, at approximately 12:45 p.m., registered nurse (RN)-B confirmed the above medications were stored unlocked in the staff bathroom. RN-B stated the medications should be stored in a locked cupboard. The licensee's Storage of Medications policy dated August 12, 2021, indicated medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	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	01890		

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01890	Continued From page 34 by: Based on observation, interview, and record review, the licensee failed to ensure medications included the expiration date for time sensitive medications for one of one resident (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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 12, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personal (ULP)-F dial R2's Levemir Flex Touch pen to 25 units and Novolog insulin pen to eight (8) units and hand the insulin pens to R2 for self-administration. The Levemir and Novolog insulin pens were not labeled with the date the insulin pens were opened or would expire. ULP-F confirmed the insulin pens were not labeled with the date the insulin pens were opened or would expire. ULP-F stated R2's insulin pens never last 28 days. On July 12, 2022, at approximately 2:00 p.m. registered nurse (RN)-B stated ULP have been trained to date the insulin pens when they are opened. The FDA (Federal Drug Administration) guidelines for Levemir Flex Touch pens, revised January 2019, indicated Levemir Flex Touch Should be discarded 42 days after they are first kept out of	01890		

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01890	Continued From page 35 the refrigerator. The FDA guidelines for Novolog insulin pens, revised December 2012, indicated Novolog insulin pens can be stored out of the refrigerator for up to 28 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910		

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licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R5) 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:

R5's Progress Notes dated March 10, 2022, indicated R5 was given medications on hand that were 2 week's worth of bubbles. R5 denies he has any questions in regards to questions on medication. R5 refuses to sign for medications.

R5 was discharged on March 10, 2022.

R5's service plan dated October 25, 2021, indicated services included medication administration.

R5's prescriber's orders dated March 9, 2022, included the following medications: one antianxiety, on anti-depressant, one antipsychotic, and one for treatment of diabetes.

R5's record lacked evidence of documentation of R5's disposition of medications to include: name of the medication, strength, prescription number if

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01910	Continued From page 37 applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On July 12, 2022, at approximately 2:00 p.m., registered nurse (RN)-B confirmed the documentation of disposition of R5's medication did not include the required content as indicated above. The licensee's Disposition or Disposal of Medications policy dated August 12, 2021, indicated documentation of the disposition or destruction, listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs and signature of witness to the destruction must be recorded in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 38 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 a treatment management plan to include all required content for one of two resident (R1) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01940		

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01940	Continued From page 39 During the entrance conference on July 11, 2022, at approximately 9:30 a.m., registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to residents. R1's service plan dated August 5, 2021, indicated R1 received treatment management services. R1's prescriber's orders dated February 25, 2022 and June 27, 2022, included respectively, orders for oxygen per nasal cannula at three (3) liters continuous and support stockings on in the am and off in the pm. On July 12, 2022, at approximately 9:00 a.m., R1 was observed in his room receiving oxygen at 3 liters per nasal cannula and wearing support stockings. R1's Treatment Management Plan dated June 22, 2022, lacked evidence the RN developed a treatment management plan to include the required content for the application of oxygen and support stockings: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
01940	Continued From page 40 complications or adverse reactions. On July 12, 2022, at approximately 2:00 p. m., RN-B confirmed she had not developed a treatment management plan for R1 as indicated above. The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated August 21, 2021, indicated the RN will document the services the client will receive on the individualized Treatment and therapy plan, No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for two of two residents (R1 and R2) with records reviewed.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
01960	Continued From page 41 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: R1 R1's prescriber's orders dated June 27, 2022, included support stockings on in the am and off in the pm. On July 12, 2022, at approximately 9:00 a.m., R1 was observed in his room wearing support stockings. R1's Service Delivery Record for June 2022, indicated the unlicensed personnel (ULP) documented the services as follows: -support stockings fifty-five (55) out of sixty (60) opportunities. R2 R2's prescriber's orders dated August 31, 2021, included catheter cares. Remind the R2 to self cath and record any refusals. R2's Service Delivery Record for June 2022, indicated the ULP documented the services as follows: -catheter cares seventy-one (71) out of ninety (90) opportunities.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
01960	Continued From page 42 R2's Service Delivery Record for July 2022, included the ULP documented the services as follows: -catheter cares thirty (30) out of thirty-three (33) opportunities. On July 12, 2022, at approximately 2:00 p.m., registered nurse (RN)-B confirmed R1 and R2 lacked documentation of the services as ordered. The licensee's Documentation of Medication, Treatment and Therapy management Services policy dated August 12, 2021, indicated staff will document each task immediately after the task has been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
02410	Continued From page 43 resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during resident COVID-19 screening and medication administration for two of four residents (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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 12, 2022, at approximately 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-F administer Olopatadine (treat symptoms of allergic conjunctivitis) one drop to each eye to R6. R6 was standing at the half door that led into the kitchen. There were several other residents standing in very close proximity to R6. The surveyor also observed ULP-F take R7's temperature and oxygen saturation level while R6	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33366	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON COLONIAL HOMES 2	4723 NYGAARD ROAD 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
02410	Continued From page 44 was standing at the half door that led into the kitchen. There were several other residents standing in very close proximity to R7. On July 12, 2022, at approximately 2:00 p.m., registered nurse (RN)-B stated eye drops and treatments should be completed in a private area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *07/11/22*
Time: 10:10:00
Report: 7983221101

Food and Beverage Establishment Inspection Report

Location:
Peterson Colonial Homes 2
4723 Nygaard Road
Brookston, MN55711
St. Louis County, 69

Establishment Info:
ID #: 0037655
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188780642
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.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

SLICED AMERICAN CHEESE AND COTTAGE CHEESE IN THE WHIRLPOOL REFRIGERATOR/FREEZER WERE NOT MARKED WITH THE DATE THAT THE ORIGINAL PACKAGES WERE OPENED. SEE GENERAL COMMENT 2 BELOW.

Comply By: 07/11/22

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

OBSERVED A FEW INSTANCES OF RE-USE OF MANUFACTURERS' SINGLE-USE CONTAINERS.

Comply By: 08/11/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE INSTAPOT, THE FRIGIDAIRE SINGLE-DOOR UPRIGHT REFRIGERATOR, THE FRIGIDAIRE SIDE-BY-SIDE REFRIGERATOR/FREEZER, AND THE WHIRLPOOL REFRIGERATOR/FREEZER

ARE DOMESTIC UNITS. SEE GENERAL COMMENT 3 BELOW.
Comply By: 04/11/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED A RIVAL CROCK-POT IN THE STOREROOM.
Comply By: 07/11/22

Food and Equipment Temperatures

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Raw shell egg in the Frigidaire single-door upright refrigerator in the storeroom.
Violation Issued: No

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

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

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

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

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Frigidaire side-by-side refrigerator was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Taco sauce in the refrigerator compartment of the Frigidaire side-by-side refrigerator/freezer.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Whirlpool refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Raw shell egg in the refrigerator compartmentof the Whirlpool refrigerator/freezer.
Violation Issued: No

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

Process/Item: Warewashing Machine
Temperature: 163 Degrees Fahrenheit - Location: Wash water temperature during the first observed cycle.

Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 180 Degrees Fahrenheit - Location: Rinse water temperature during the second observed cycle.

Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Plate/utensil surface temperature during the first and second observed cycles.
Violation Issued: No

Process/Item: Countertop Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Milk.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 37 Degrees Fahrenheit - Location: Potato salad in the Turbo Air single-door upright refrigerator.
Violation Issued: No

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

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GENERAL COMMENTS:

1) Discussed employee illness. Observed handwashing and glove use.

2) Either date the cottage cheese when the manufacturer's container is first opened or contact the manufacturer to determine if the cottage cheese is not time/temperature control for safety (TCS) food (based on pH and water activity) and, therefore, doesn't require date-marking.

3) Alternately, TCS food may be prepared for same-day service only.

4) Provided employee illness materials, a temperature requirement fact sheet, a date-marking fact sheet, and a time/temperature control for safety (TCS) food fact sheet.

5) The establishment ceased to employ a certified food protection manager (CFPM) approximately 30 days prior to the date of this inspection. Please note that a new CFPM must be employed within 60 days of the date that the previous CFPM left employment.

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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 7983221101 of 07/11/22.

Certified Food Protection Manager: Tammie Johnson

Certification Number: Pending. Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: 7983

Tammie Johnson
Person in Charge

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