



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

April 2, 2025

Licensee
The Pillars of Hermantown
4110 Lavaque Road
Hermantown, MN 55811

RE: Initial License Number 415554
Health Facility Identification Number (HFID) 40711
Project Number(s) SL40711015

Dear Licensee:

On March 24, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed November 6, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective April 2, 2025.

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 6, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on November 6, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on March 24, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2025
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF HERMANTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 4110 LAVAQUE ROAD HERMANTOWN, MN 55811		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL40711015-1 On March 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 6, 2024. At the time of the survey, there were 118 residents; 55 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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	{0 780}			

Minnesota Department of Health
STATE FORM 6899 7YES12 If continuation sheet 4 of 7

Minnesota Department of Health

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{0 810}	Continued From page 4 per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{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 were maintained bearing legible information including the expiration date for time sensitive medications and expired medications were removed from the medication cart for three of 21 residents (R2, R6, R12). 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	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 5 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2, R6, and R12 were admitted to the licensee on June 24, 2024, July 2, 2024, and March 29, 2024, respectively. R2, R6, and R12's Service Plan Agreements with effective dates of March 21, 2025, March 18, 2025, and March 20, 2025, respectively, read, "medications will be destroyed per [licensee] policy when service plan ends, medication management is no longer a part of the service plan, discontinued medications, expired medications or if the resident is discharged or deceased." On March 24, 2024, at 10:35 a.m., the surveyor completed an audit of licensee's medication cart located in the secured dementia care unit. The following 3 medications were identified with either no expiration date or the medication was past the expiration date: - R2's Novolog FlexPen (a device used to administer insulin to a person) lacked a required expiration date when the insulin was opened to prevent the administration of an expired time sensitive medication. - R6's over the counter glucose tablets (a medication used when a person with diabetes suffers a low blood sugar reading) lacked an expiration date on the original container. - R12's diclofenac cream (a cream used to aide in pain relief) had an expiration date of March 14, 2025. On March 24, 2025, at 10:45 a.m., the above identified medications were provided to clinical	{01890}			

Minnesota Department of Health

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{01890}	Continued From page 6 nurse supervisor (CNS)-C who stated the medications should have not be present in the medication cart. CNS-C stated R2's and insulin for all residents should be labeled with the appropriate opened on date when the insulin is removed from the refrigerator as each insulin have a specific time frame from when the insulin is placed in the medication cart. CNS-C stated R6's glucose tablets were brought to the facility when R6 moved in but have never been administered. CNS-C stated the glucose tablets should have never been labeled and placed in the medication cart as the container did not include an expiration date. CNS-C stated R12's diclofenac cream should have been removed during the licensee's medication cart audits but must have been missed the previous week. CNS-C stated all staff are trained to check expiration dates, but staff must have not completed the checks as trained. CNS-C stated the identified medications would all be required to be destroyed per licensee's policy. The licensee's Storage of Medication and Key Security dated April 12, 2023, indicated all medications would include expirations dates and medications would be stored and managed as required by the manufacture. No further information provided.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

February 4, 2025

Licensee
The Pillars of Hermantown
4110 Lavaque Road
Hermantown, MN 55811

RE: Provisional Conditional License Number 415554
Health Facility Identification Number (HFID) 40711
Project Number(s) SL40711015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **April 5, 2025**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 may be 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$3,000.00. **MDH is not imposing**

these fines against your provisional license at this time.

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

CONDITIONAL LICENSE ISSUED:

MDH will issue The Pillars of Hermantown a conditional provisional assisted living facility license with dementia care for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Pillars of Hermantown is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license with dementia care:

- a. No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. No new admissions:** The Pillars of Hermantown will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. The Pillars of Hermantown must provide the Department:
 - i. A list of the names and birthdates of any individuals The Pillars of Hermantown

is currently in the process of admitting. These individuals will be able to continue the admittance process.

- ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if The Pillars of Hermantown is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines The Pillars of Hermantown is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to The Pillars of Hermantown. If MDH determines The Pillars of Hermantown is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL40711015 On November 4, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 89 residents; 51 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on November 5, 2024, for correction order 2310, issued at a scope and level of level three, widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 3, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and 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	0 780			

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0 780	Continued From page 4 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). Findings include: On facility tour with the licensed environmental services director (ESD)-K on November 5, 2024, between 9:00 a.m. and 2:00 p.m. the following deficient conditions were observed: DEMENTIA CARE AREA: The surveyor observed there was not an egress control locking system having the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. The surveyor explained to ESD-K that a compliant signal or switch shall be installed. This code section requiring the signal or switch was identified on the original building plan reviewed by the surveyor. The deficient condition was visually verified by ESD-K accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days SLIDE BOLT LOCK: The surveyor observed a slide bolt lock on the kitchen side of the door from the kitchen to the back corridor. This is a required egress door from this area.	0 780			

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0 780	Continued From page 5 The surveyor explained to the ESD-K that this lock shall be removed and that at least one door from this corridor shall be readily openable from the egress side without the use of a key or special knowledge or effort. LAUNDRY ROOM: The surveyor observed that the fusible link for the laundry chute door was broken and missing. The chute door was held open with a plastic zip tie. The surveyor explained to the ESD-K that the fusible link of the same type as provided when installed shall be installed. CEILING TILE: The surveyor observed several ceiling tiles were missing in the 2nd floor community storage room, garage storage area and craft room in the garage area. The surveyor explained to the ESD-K that all ceiling tiles shall be always kept in place to activate the fire sprinkler system in the area sooner and to keep smoke from getting into the concealed space. CORRIDOR STORAGE: The surveyor observed a scooter in the 3rd floor corridor actively being charged. The surveyor explained to the ESD-K that the corridor and stairwells shall be always kept free of storage. FIRE DOOR:	0 780			

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0 780	Continued From page 6 The surveyor observed the fire doors in the dementia care side by resident room 132 that did not close and latch when tested. The surveyor explained to the ESD-K that all fire doors shall close and latch when tested or the fire alarm system release them. OXYGEN USE: The surveyor observed there was not an oxygen in use sign outside resident room 215 and the resident was using oxygen. The surveyor explained to the ESD-K that all rooms that have oxygen stored or in use shall have a sign indicating this outside at the door to the room. These deficient conditions were visually verified by the ESD-K accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
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) staff 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,	0 810			

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0 810	Continued From page 7 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop the fire safety and evacuation plan with the required content and failed to conduct the required evacuation drills. This had the potential to directly affect all 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 potential to affect a large portion or all of the residents).	0 810			

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0 810	Continued From page 8 The findings include: A record review and interview were conducted on November 6, 2024, at approximately 12:00 p.m. with the licensed environmental services director (ESD)-F on the fire safety and evacuation plan for the facility. FIRE/EVACUATION PLAN: During record review the surveyor observed the fire safety evacuation plan had a great amount of information that did not pertain to this facility. It shall be updated to only have information pertaining to this facility. The ESD-F stated they do not have a signed contract with another facility to house and a transportation company to move residents to if the facility needs to be evacuated. The fire safety and evacuation plan binder were missing resident evacuation capabilities, the staging area outside the facility and the facility diagram. The surveyor explained to the ESD-F that a written signed agreement shall be in place with another facility and a transportation company and shall be updated annually. The fire safety and evacuation plan shall be updated and always available and accessible within the facility, the facility diagram shall be in the binder and the location of the staging outside the building shall be identified. FIRE DRILLS: During record review the surveyor observed that	0 810			

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0 810	Continued From page 9 the fire drills had not been completed and documented on all shifts. The ESD-F stated they had combined a couple of shifts during some of the drills. The surveyor explained to the ESD-F that evacuation drills are to be completed and documented with employee signatures, twice per year per shift with at least one evacuation drill every month. These fire drills shall be completed with only the number of employees that are normally on that shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	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	01060			

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01060	Continued From page 10 (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 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 notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R7). 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).	01060			

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01060	Continued From page 11 The findings include: R7's service plan dated August 23, 2024, indicated R7 received assistance with bed mobility, ambulation, transfers, toileting, compression stockings (TEDs), medication administration, and housekeeping services. Progress notes for R7 included: -August 15, 2024, 6:00 a.m., registered nurse (RN) instructed staff to call EMS (emergency medical services) -August 15, 2024, 10:04 a.m., report taken from (name of hospital). Plan is to admit to hospital. Diagnosis of pneumonia of left lower lobe. No plans for discharge as of yet. -August 22, 2024, 4:07 p.m., resident returned from hospital at 1500 (3:00 p.m.), via medical transport. R7's record lacked a written notice that contained, at a minimum: - notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - 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. On November 4, 2024, at 1:01 p.m., licensed assisted living director in residency (LALDR)-A stated the licensee had relocation forms however	01060			

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01060	Continued From page 12 the forms were not completed. LALDR-A added she had called the clinical nurse supervisor (CNS)-C and asked her if the forms were completed and was told by CNS-C the forms were not completed. On November 4, 2024, at 2:49 p.m., LALDR-A stated they (licensee) had figured out a process to ensure OOLTC notice got sent out when leave of absents occurred. On November 5, 2024, at 11:56 a.m., CNS-C stated they [licensee] sent her through four days of training for assisted living requirements. CNS-C said OOLTC relocation notice had been discussed during the training, and it [relocation training] went "over my head" as CNS-C motioned above her head. The licensee's Resident Agreement Termination-Emergency Relocation policy dated August 2021, noted in the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: -the reason for the relocation -the name and contact information for the location to which the resident had been relocated and any new service provider -contact information for the Office of Ombudsman for Long-Term Care -if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known, and -a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility would provide contact information for the agency to which the resident may submit an appeal.	01060			

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01060	Continued From page 13 The notice required for emergency relocation would be delivered as soon as practicable to: -the resident, legal representative, and designated representative -resident's case manager if on wavered services: and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01550 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for two of two employees, (chef (C)-F, housekeeping (H)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01550			

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01550	Continued From page 14 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: During the entrance conference on November 3, 2024, at 10:00 a.m., registered nurse (RN)-B and licensed assisted living director in residency (LALDR)-A stated the current censuses in the memory (dementia care) unit at the facility was 18 residents. C-F The facility's staff roster noted C-F was hired on January 3, 2022. On November 4, 2024, at 3:11 p.m. LALDR-A stated C-F was transferred to this facility from another facility owned by the licensee. LALDR-A stated C-F's record should be reviewed as a new employee. LALD-A confirmed C-F had been employed greater than 160 hours. On November 6, 2024, at 9:31 a.m., the surveyor observed C-F exit the kitchen. C-F stated the evaluator should speak to him (C-F) if there were any questions or concerns with the kitchen or food service at the facility. C-F's record included: -person-centered care principles, (.5 credits) dated January 31, 2023 -dementia management and abuse prevention dated January 14, 2022 -dementia part one, dementia basics dated	01550			

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01550	Continued From page 15 January 14, 2022 -dementia part three, dementia communication dated January 17, 2022 -dementia part four, activities of daily living dated January 17, 2022 -dementia part five, problem solving with challenging behaviors dated January 17, 2022 -dementia part six A, creative engagement dated January 17, 2022 -dementia part six B, creative engagement dated January 17, 2022 -dementia part six C, creative engagement dated January 17, 2022 -dementia part six E, creative engagement dated January 17, 2022 -dementia part six F, creative engagement dated January 17, 2022. C-F's record did not include four hours of dementia training completed within 160 hours of employment start date, or two hours for each 12 months of employment. H-G H-G was hired on September 9, 2024. On November 4, 2024, at 2:48 p.m., LALDR-A stated H-G had been employed more than 160 hours. LALDR-A added, H-G worked 40 hours per week. H-G's record included: -dementia management and abuse prevention, assigned September 5, 2024, not started -dementia part one, dementia basics, assigned September 5, 2024, not started -dementia part three, dementia communication, assigned September 5, 2024, not started -dementia part four, activities of daily living, assigned September 5, 2024, not started	01550			

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01550	Continued From page 16 -dementia part five, problem solving with challenging behaviors, assigned September 5, 2024, not started -dementia part six A, creative engagement, assigned September 5, 2024, not started -dementia part six B, creative engagement, assigned September 5, 2024, not started -dementia part six C, creative engagement, assigned September 5, 2024, not started -dementia part six E, creative engagement, assigned September 5, 2024, not started -dementia part six F, creative engagement, assigned September 5, 2024, not started. H-G's record did not include four hours of dementia training completed within 160 hours of employment start date. On November 4, 2024, at 3:16 p.m., LALDR-A stated she, "did not have any excuse" as to why dementia education had not been completed as required for C-F and H-G. LALDR-A said dementia education non-completion for non-direct staff was a widespread issue. LALDR-A added direct care staff had the required dementia training completed. The licensee's Dementia-Specific Training policy dated May 2022, noted the (name) of company's staff was expected to complete dementia specific training as required by regulations and job function. Dementia training was provided during New Employee Orientation and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550			

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01650	Continued From page 17	01650			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R4, R6, R9). This practice resulted in a level two violation (a	01650			

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01650	Continued From page 18 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: R4 R4's diagnoses include Alzheimer's disease. R4's service plan dated October 31, 2024, indicated R4 received the following services: grooming assist, toileting assist, bathing, skin condition monitoring, ambulation cueing, meal escort, safety checks, wandering assist, emergency evacuation assist, orientation and behavior management, medication administration, and housekeeping services. On November 6, 2024, at 8:35 a.m., the surveyor observed registered nurse (RN)-D obtain R4's vital signs. R4's service plan did not include the following required content: - the methods of monitoring assessments of the resident - the schedule and methods of monitoring staff providing services - information and a method to contact the facility - a contingency plan that included the action to be taken if the scheduled service cannot be provided, and -the circumstances in which emergency medical services are not to be summoned consistent with chaplets 145B and 145C, and declarations made by the resident under those chapters.	01650			

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01650	Continued From page 19 R6 R6's diagnoses include diabetes, mild cognitive impairment, Alzheimer's disease, and hypertension (high blood pressure). R6's service plan dated August 5, 2024, indicated R6 received the following services: blood glucose monitoring, insulin administration, inhaler assisted, oral medication administration, and housekeeping services. On November 5, 2024, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R6's morning medication and monitor R6's blood glucose (sugar). R6's service plan did not include the following required content: - the schedule and methods of monitoring assessments of the resident - the schedule and methods of monitoring staff providing services - information and a method to contact the facility - a contingency plan that included the action to be taken if the scheduled service cannot be provided, and -the circumstances in which emergency medical services are not to be summoned consistent with chaplets 145B and 145C, and declarations made by the resident under those chapters. R9 R9's diagnoses include bradycardia (slow heartbeat), weakness, difficulty in walking, mild cognitive impairment, adjustment disorder with mixed anxiety and depressed mood, and other lack of coordination: asterixis (brain-related symptom that causes muscles to relax briefly while using them).	01650			

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01650	Continued From page 20 R9's service plan dated September 19, 2024, indicated R9 received the following services: bathing, dressing, and medication reminders. On November 5, 2024, at 6:53 a.m., the surveyor observed ULP-J assist R9 with dressing. R9's service plan did not include the following required content: - the schedule and methods of monitoring assessments of the resident - the schedule and methods of monitoring staff providing services - information and a method to contact the facility - a contingency plan that included the action to be taken if the scheduled service cannot be provided, and -the circumstances in which emergency medical services are not to be summoned consistent with chaplets 145B and 145C, and declarations made by the resident under those chapters. On November 4, 2024, at 4:12 p.m., RN-E stated "you are correct" the service plans for all of the current residents do not include all of the required content. RN-E added he noticed a box in the computer system used by the licensee had not been checked. RN-E said he corrected the error and would print off new service plans for all of the residents that would include the required information and get the service plans out for signatures. The licensee's Service Plan Agreement Content policy reviewed December 2, 2020, noted the service plan would include: - the schedule and methods of monitoring reviews or re-assessments of the client (resident) - the frequency of supervision of staff providing	01650			

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01650	Continued From page 21 services and the identification of the supervisor(s) who would be providing the supervision - a contingency plan that included: a. the action to be taken by our agency, the client and/or client's representative if the scheduled service cannot be provided-b. information and method for a client or client's representative to contact our agency c. names and contact information of person the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency d. the circumstances in which emergency medical services are not to be summoned pursuant to provider orders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750			

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01750	Continued From page 22 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) prepared in writing specific instructions for each resident and documented those instructions for one of four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's diagnoses include diabetes, mild cognitive impairment, Alzheimer's disease, and hypertension (high blood pressure). R6's service plan dated August 5, 2024, indicated R6 received the following service: inhaler assist. On November 5, 2024, at 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-I gather R6's morning medication which included a Pulmicort Flexhaler 180 micrograms (mcg) inhaler (reduces the swelling/inflammation, in the lungs). R6's medication administration record (MAR) dated November 1, 2024, through November 4, 2024, included: -Pulmicort Flexhaler 180 mcg inhale two puffs twice daily.	01750			

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01750	Continued From page 23 R6's prescriber's order dated October 15, 2024, included: -budesonide 180 mcg/actuation breath activated power inhaler (Pulmicort Flexhaler), two inhalations inhalation, BID (two times daily). On November 5, 2024, at 8:04 a.m., the surveyor observed ULP-I enter R6's room. ULP-I stated, "let's do medication first, I (ULP-I) have some water for you". ULP-I administered R6's oral medication. ULP-I handed R6 the Pulmicort inhaler and instructed R6, "you are going to do it twice, one long breath in." R6 took one long breath in. R6 "clicked" the inhaler and took another long breath in. ULP-I prepared to monitor R6's blood glucose. R6's MAR did not include specific instructions for R6's inhaler to rinse mouth out after each use. On November 5, 2024, at 8:12 a.m., the surveyor reviewed the manufacturer's instructions located in R6's Pulmicort Flexhaler box with ULP-I. ULP-I stated R6's MAR did not include the specific instructions to rinse mouth with water and spit the water out after each dose of the Pulmicort Flexhaler. Do not swallow the water. On November 5, 2024, at 11:04 a.m., the surveyor reviewed the manufacturer's instructions found in the box of R6's Pulmicort inhaler with clinical nurse supervisor (CNS)-C. CNS-C confirmed R6's MAR did not include specific instruction for R6's inhaler use. The manufacturer's instructions for Pulmicort Flexhaler dated September 2024, noted rinse mouth with water and spit the water out after each dose of the Pulmicort Flexhaler. Do not swallow the water. Pulmicort Flexhaler can cause	01750			

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01750	Continued From page 24 serious side effects, including thrush (candida/yeast), a fungal infection in your mouth and throat. The licensee's Unlicensed Personnel-Medication Administration policy reviewed August 1, 2021, noted the RN had developed written, specific instructions for each client (resident) for administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (R3) who received medication	01760			

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01760	Continued From page 25 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: R3's diagnoses include memory impairment, atrial fibrillation (A-fib an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). hypertension (high blood pressure), and history of CVA (cerebrovascular accident: stroke/when blood supply to part of the brain is blocked or reduced). R3's service plan dated July 28, 2024, indicated R3 received medication administration. R3's prescriber's order dated October 25, 2024, included: -aspirin 81 milligrams (mg) (heart health) chewable tablet, daily. R3's medication administration record (MAR) dated November 1, 2024, through November 4, 2024, included: -aspirin 81 mg chewable tablet (Bayer aspirin 81 mg chewable) "CHEW AND SWALLOW ONE TAB (tablet) BY MOUTH ONCE DAILY. Set up in Medi planner (seven day, preset up medication dosage box). Notify nurse immediately with concerns or questions! Pill description: round, yellow "81".	01760			

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01760	Continued From page 26 On November 5, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-H review R3's electronic (E)MAR. ULP-H removed R3's medication from the locked medication cart which were in a Medi planner. ULP-H placed the medication from the Tuesday a.m., Medi planner into a medication cup. ULP-H commented she would administer R3's eye drop "later" (R3 was currently at the dining room table). ULP-H took the medication cup to the dining room table and administered R3's oral medication. The surveyor did not see ULP-H administer R3's aspirin 81 mg as instructed on the EMAR. On November 5, 2024, at 8:29 a.m., ULP-H stated R3's aspirin should have been separated from R3's other medication. ULP-H added, R3 should have chewed the aspirin, as directed on the EMAR. On November 5, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated R3's aspirin should have been chewed by R3. CNS-C said the direction on R3's EMAR should have been followed. The licensee's Medication Administration: Oral from Bubble Packs policy reviewed August 1, 2021, noted staff (ULP) would follow instructions on the MAR/EMAR for any special pill preparation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

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01880	Continued From page 27	01880			
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 secured in one of four medication carts (third floor). In addition, the licensee failed to ensure the medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one of one medication refrigerator. 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). SECURE MEDICATION STORAGE On November 5, 2024, at 8:53 a.m., the surveyor observed unlicensed personnel (ULP)-J unlock the medication cart located on the third floor of the facility positioned in an unlocked room labeled, "laundry access to mechanical/electrical." ULP-J returned R11's unused medication to the medication cart and documented R11's medication administration. The surveyor did not observe ULP-J lock the third-floor medication cart.	01880			

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01880	Continued From page 28 On November 5, 2024, at 8:57 a.m., the surveyor observed ULP-J assist R7 with a transfer out of bed with the aid of a transfer belt and into the bathroom, apply compression stockings (TEDs), assist with dressing, assist with R7's ambulation to the dining/living area, and assist with R7's jewelry. On November 5, 2024, at 9:26 a.m., ULP-J returned to the third-floor unlocked medication cart. ULP-J said, "I am sorry, it [medication cart] should have been locked. ULP-J added that was "not good" [medication cart not being found locked]. On November 5, 2024, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated medication carts should be locked when not in use. MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On November 4, 2024, at 10:40 a.m., the surveyor observed a locked medication refrigerator during a tour of the facility with registered nurse (RN)-B. RN-B stated she thought the temperature of the medication refrigerator should be 38-42 degrees Fahrenheit (F). RN-B stated the facility used a "self-reporting" system for monitoring the medication refrigerator's temperature. The surveyor requested the temperature log for the medication refrigerator. On November 4, 2024, at 12:27 p.m., licensed assisted living director in residency (LALDR)-A provided the surveyor with the medication refrigerator log. The log provided did not have the documented temperature, rather alerts which were color coded. LALDR-A made a phone call	01880			

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01880	Continued From page 29 and asked about the "threshold" for the medication refrigerator. On November 4, 2024, at approximately 12:45 p.m., the surveyor reviewed the temperature log with LALDR-A. LALDR-A confirmed several of the medication refrigerator's temperature readings were below 36 degrees F. On November 4, 2024, at 12:55 p.m., the surveyor reviewed the medication refrigerator's temperature log with RN-B. The temperature log dated October 1, 2024, through November 4, 2024, indicated the following: - the temperature was recorded 35 of 35 opportunities: and - nine out of 35 opportunities indicated the temperature was below 36 degrees F. On November 4, 2024, at 1:04 p.m., the surveyor and RN-D observed and confirmed the contents of the medication refrigerator included the following medication: - three unopened Lantus 100 units/milliliter (ml) (long acting) insulin pens for R6. Directly after the above observation RN-D stated she would contact the pharmacy regarding R6's refrigerated insulin. The manufacturer's instructions for Lantus pen insulin dated August 2022, directed before opening store Lantus in the refrigerator 36-46 degrees F. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, noted all medications administered by staff would generally be kept in the secured storage area. When secured storage of the medications was	01880			

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01880	Continued From page 30 necessary, the nurse would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. There was a process to transfer medication keys between staff members at the change of shift. Medication keys are kept in a secure location when not in the possession of authorized personnel. Keys used to secure the designated space for medication storage may not leave the building. If keys are missing, the nurse should be notified immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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 were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of five residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

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01890	Continued From page 31 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 November 4, 2024, at 10:42 a.m., the surveyor toured the facility with registered nurse (RN)-B, to include four locked medication carts. RN-B observed and confirmed the following: -R3's opened timoptic 0.5 % eye solution (high eye pressure) included a date of October 20, (no year was noted) -R5's opened fluticasone/salmeterol 250-50 micrograms (mcg) inhaler (to open airways of the lungs, making it easier to breathe) included an opened date of September 17, 2024, and expiration date of September 17, 2025. Directly after this observation RN-B reviewed the manufacturer's directions of R3's timoptic eye solution with the surveyor. RN-B stated R3's timoptic eye solution lacked an expiration date as required. On November 4, 2024, at 10:51 a.m., RN-B confirmed R5's fluticasone/salmeterol inhaler was dated incorrectly. On November 5, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-C stated time sensitive medication should be dated to include the full and correct date the medication was opened and the expiration date.	01890			

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01890	Continued From page 32 The manufacturer's instructions for timoptic eye solution dated February 2020, noted discard the bottle 28 days after opening, even if there was solution remaining. The manufacturer's instructions for fluticasone/salmeterol inhaler dated January 2020, noted write the date you opened the pouch on the first line of the label and the "use by" date on the second line of the label. The "use by" date is one month after the date you opened the pouch. The licensee's Storage of Medication and Key Security policy dated April 19, 2023, noted until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310			

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02310	Continued From page 33 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with an assistive device (consumer bed rail), for one of one resident (R9). Further, based off observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with an assistive device (hospital bed rail) for one of one resident (R4). In addition, based off observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning supplies. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This resulted in an immediate correction order on November 5, 2024. Correction order amended on November 7, 2024, to add additional information. The findings include: CONSUMER BED RAILS	02310			

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02310	Continued From page 34 R9's diagnoses include bradycardia (slow heartbeat), weakness, difficulty in walking, mild cognitive impairment, adjustment disorder with mixed anxiety and depressed mood, and other lack of coordination: asterixis (brain-related symptom that causes muscles to relax briefly while using them). R9's service plan dated September 19, 2024, indicated R9 received the following services: bathing, dressing, and medication reminders. R9's change of condition assessment, hospitalized, dated September 19, 2024, noted: -does resident use assistive equipment for mobility? yes -walker: four wheeled -independent with cleaning and maintenance of assistive equipment -indicate level of assistance needed for getting in and out of bed: independent -does the resident use a bed rail/halo device (also may be called side rails, bed side rails, HALO (brand name) device, half rails, safety rails, bed handles, assist bars, grab bars, hospital bed rails, and adult portable bed rails? no. R9's assessment dated September 19, 2024, was lacking a bed rail assessment. R9's record included the form, Bed Rails-Intended Purpose, Potential Risks and Client Agreement, dated April 9, 2024, which indicated R9 had been given "a Guide to Bed Safety" and understood the benefits and risks associated bed rails. The form included: I agree not to use or apply bed rails of any type without first notifying facility and allowing facility to conduct an assessment to determine the risk/benefit of bed rail use. I acknowledge bed	02310			

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02310	Continued From page 35 rails are most often considered a restraint and may cause serious injury including fractures, asphyxiation, strangulation, and death. In the event it is determined by facility staff that the bed rail(s) poses a greater risk for injury than benefit for my use. I agree to not apply/utilize the bed rails (s). -per my signature below, I have made the decision to: decline to use a bed rail. On November 5, 2024, at 6:53 a.m., the surveyor observed a consumer type of bed rail on both sides of R9's bed. The surveyor observed unlicensed personnel (ULP)-J assist R9 with dressing. R9 used the bed rail positioned on the side of the bed nearest to the bathroom to steady himself while seated on the side of the bed. R9 stated he used the side rails and "I'd never get by without them (bed rails)." R9 later used the bed rail when he transferred out of the bed. On November 5, 2024, at 2:46 p.m., clinical nurse supervisor (CNS)-C stated there was not an assessment for R9's bed rails. CNS-C stated family must have brought the bed rails in. CNS-C said "someone" added the bedrail to the resident roster. CNS-C added she was not aware of R9's bed rails. On November 5, 2024, at 2:59 p.m., CNS-C and registered nurse (RN)-E reviewed the resident roster and stated there was only one bed rail in use at the facility, R9. CNS-C added "I am guessing" when R9 returned from the hospital the bed rails were added. On November 5, 2024, at 3:06 p.m., RN-E stated CNS-C was "going up" to R9's room to complete a bed rail assessment and the licensee was familiar with the requirements.	02310			

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02310	Continued From page 36 HOSPITAL BED RAILS R4 R4 diagnoses include Alzheimer's disease. R4's service plan dated October 31, 2024, indicated R4 received the following services: grooming assist, toileting assist, bathing, skin condition monitoring, ambulation cueing, meal escort, safety checks, wandering assist, emergency evacuation assist, orientation and behavior management, medication administration, and housekeeping services. R4's move in assessment dated October 31, 2024, included: -does resident use assistive equipment for mobility? yes -walker: two wheeled -indicate level of assistance needed for getting in and out of bed: independent -does the resident use a bed rail/halo device, half rails, safety rails, bed handles, assist bars, grab bars, hospital bed rails, and adult portable bed rails? no. R4's assessment dated October 31, 2024, was lacking a bed rail assessment. On November 6, 2024, at 8:35 a.m., the surveyor observed R4 sitting on the floor in his room in front of a recliner. RN-D was assessing R4 and obtained R4's vital signs. The surveyor observed a hospital bed next to R4's recliner. The hospital bed was made but the bedspread did not lay smoothly over the side of the bed nearest to the wall. The surveyor observed an upper half bed rail in the lowered position attached to R4's hospital bed. The bed rail was not secured in the lowered position.	02310			

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02310	Continued From page 37 On November 6, 2024, at 8:38 a.m., RN-B entered R4's room. RN-B stated she was not aware there was a bed rail on R4's bed. RN-B added R4 had been admitted on Halloween (October 31, 2024). The surveyor raised the bed rail. The surveyor was not able to lower the bed rail. RN-B attempted to lower the bed rail and was unsuccessful to lower the bedrail. On November 6, 2024, at 8:43 a.m., RN-D stated she was not aware there was a bed rail on R4's bed. On November 6, 2024, at 8:44 a.m., RN-B removed the bed rail from R4's bed. On November 6, 2024, at 9:12 a.m., CNS-C stated R4 "just moved in." CNS-C added family said R4's hospital bed had a bed rail on it but the bed rail was not in use. CNS-C stated as long as they (bedrail's) were not used, and in the lowered position, bed rails attached to beds were "ok." On November 6, 2024, at 9:57 a.m., RN-E stated, "a bed rail was a bed rail" and should have been removed if not in use, an assessment had not been completed, and an order sought for the bed rail. RN-E confirmed an assessment for R4's bed rail was not completed as required. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must	02310			

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02310	Continued From page 38 be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include	02310			

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02310	Continued From page 39 in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Assessment and Use of Side Rails policy dated December 2, 2020, noted when notified that a client (resident) had a side rail, the nurse would assess and evaluate the client's needs are and assess to determine if the client could appropriately utilize the side rail/equipment. The nurse would ensure that the device does not inhibit resident from being able to move about freely and was not determined to be a restraint. The nurse would determine whether the side rail/equipment meets the following facility required standards. -homestyle beds: the facility approved device would be halo device. The device would need to be installed/maintained per manufacturer's guidelines. The device would need to be maintained and ensure there was no broken/ malfunctioning parts of the rail to remain in place in the resident' apartment. If the resident wished to use a device other than the halo, the facility would assess to ensure the device met safety standards including but not limited to the following: - meets assessed safety requirements for resident's individual needs -has manufacturer information available and is able to be installed per those guidelines -no side under/strap down devices, must be bolted to the frame -no zones large enough for entrapment -no modifications made to the device not indicated in manufacturer guidelines. The nurse would document these recommended options and the response from the client, client's family, and client's representative to the nurse's	02310			

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02310	Continued From page 40 recommendations. CLEANING SUPPLIES The assisted living with dementia care facility had a secured dementia care unit with a current censuses of 18 residents. On November 5, 2024, at 11:42 a.m., the surveyor and environmental service director (ESD)-K observed the door to R10's room open and several containers of cleaning products located in an unlocked cabinet under the kitchen sink in R10's room in the dementia care unit of the facility. ESK-K observed and confirmed the following products: -an opened bottle of Windex "unbeatable streak free" window cleaner -an opened Endust, "end dust and clean" can -an opened can of Comet with bleach -an opened bottle of Clorox cleaner with bleach. The surveyor and ESD-K also observed the following items located in an unlocked cabinet under the bathroom sink in R10's room: -a used can of tropical mist Glade room deodorizer -a container of Scrubbing Bubble "bathroom grime fighter" unsure if used/ opened or not -an opened container of Lysol disinfecting mango and hibiscus wipes. Directly after the above observation ESD-K removed the above noted items. ESD-K confirmed the items should have been secured. On November 5, 2024, at 11:47 a.m., CNS-C stated the licensee had a form "What to Bring/What NOT to Bring when Moving into Memory Care." CNS-C pointed at the "What to Bring/ What NOT" undated form's highlighted section:	02310			

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02310	Continued From page 41 - Items NOT allowed in memory care, due to safety, which included: poisons (cleaning and household products. CNS-C stated "that would have been terrible" [if a resident found/used the above listed items]. On November 5, 2024, at 11:56 a.m., CNS-C said the resident in room 130, (R10) just returned to the facility "yesterday." CNS-C added "the family must have thought they were being helpful" [with supplying the cleaning products]. On November 6, 2024, at 10:12 a.m., RN-E stated the facility did not have any safety sheets on the cleaning products found in R10's room. RN-E added, "as they [cleaning products] were not "their [licensees] cleaning products." RN-E stated R10's family brought the products into R10's room. RN-E confirmed the products found in R10's room could have caused harm. On November 6, 2024, at approximately 10:15 a.m., regional director/ULP (RO/ULP)-M stated the cleaning products found unsecured in R10's room did not belong to the licensee. RO/ULP-M handed the surveyor a policy, Safekeeping of Resident's Possessions dated August 1, 2021, and included: -in an effort to maintain the safety of resident's personal belongings, the facility staff would, attempt to minimize unwanted occurrences of residents entering another resident's apartment unit -in an effort to maintain the safety of resident's personal belongings, the resident and/or representative was encouraged to not bring valuables, lock their apartment door, if resident was cognitively able to do so, check personal belongings frequently, so that if something was missing, we have a reasonable timeframe to work	02310			

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02310	Continued From page 42 with when investigating the loss, report any missing items to the On November 6, 2024, at 10:16 a.m., CNS-C stated, yes, the products found in R10's room could have caused harm. WINDEX STREAK-FREE (window cleaner) Safety Data Sheet dated January 1, 2018, noted: Avoid contact with skin, eyes and clothing. KEEP OUT OF REACH OF CHILDREN AND PETS ENDUST (end dust and cleaning product) Safety Data Sheet dated June 25, 2019, noted: Warning, flammable aerosol, may cause an allergic skin reaction, may cause drowsiness or dizziness. Avoid breathing dust/fume/gas/mist/vapors/spray. Use only outdoors or in a well-ventilated area. Contaminated work clothing must not be allowed out of the workplace. Wear protective gloves. If on skin: wash with plenty of soap and water. If inhaled: remove person to fresh air and keep comfortable for breathing. Call a Poison Center/doctor if you feel unwell. If skin irritation or rash occurs get medical advice/attention. Wash contaminated clothing before reuse. Store in a well-ventilated place. Keep container tightly closed. Store locked up. COMET WITH BLEACH Safety Data Sheet dated June 18, 2015, noted: Warning: causes eye irritation. Wash hands thoroughly after handling. Keep only in original container. Do not mix with other cleaning products or chemicals as irritating fumes may be formed. If in eyes: rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists, get medical advice/attention. If	02310			

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02310	Continued From page 43 swallowed: drink one or two glasses of water. Storage: keep container closed when not in use. Never return spills in original containers for re-use. Keep out of the reach of children. CLOROX CLEAN-UP CLEANER WITH BLEACH Safety Data Sheet dated December 20, 2022, noted: Warning: causes serious eye irritation, wash thoroughly after handling. Wear eye protection and face protection. If in eyes: rinse cautiously with water for several minutes. Remove contact lenses. If present and easy to do. Continue rinsing. If eye irritation persists, get medical attention. Ingestion: do not induce vomiting. Never give anything by mouth if victim is unconscious or is convulsing. If vomiting occurs natural, have victim lean forward to reduce risk of aspiration. Get medical attention if feel unwell. If you feel unwell seek immediate medical advice (show the label where possible.) KEEP OUT OF REACH OF CHILDREN AND PETS GLADE TROPICAL MIST (room deodorizer) Safety Data Sheet dated November 5, 2009, noted: Potential health effects: exposure routes: eye, skin, inhalation, ingestion. -eye contact: flush immediately with plenty of water for at least 15 to 20 minutes. Get medical attention if irritation develops and persists. -skin contact: rinse with plenty of water -inhalation: remove to fresh air. If breathing is affected, get medical attention -ingestion: rinse mouth with water. Consult a physician if necessary. KEEP OUT OF REACH OF CHILDREN AND PETS, do not puncture, or incinerate. Use only as directed.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF HERMANTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 4110 LAVAQUE ROAD HERMANTOWN, MN 55811		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 44 CLOROX DISINFECTING WIPES Safety Data Sheet dated 2020, noted: Caution causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. Wear gloves for prolonged or frequent use. First aid if in eyes: hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first five minutes, then continue rinsing eye. Call a poison control center or doctor for further treatment advice. Have the product container or label with you when calling a poison control center or doctor or going for treatment. SCRUBBING BUBBLES (bathroom grime fighter) Safety Data Sheet dated February 1, 2019, noted: Do not mix with bleach or any other household cleaners, if accidental missing occurs and toxic gas is formed, exit area immediately. Do not return until well ventilated. Avoid contact with skin, eyes, and clothing. KEEP OUT OF REACH OF CHILDREN AND PETS. The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to date service plan subject to accepted health care standards. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF HERMANTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 4110 LAVAQUE ROAD HERMANTOWN, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 45	02320			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the treatment of blood glucose (sugar) monitoring was completed as instructed by one of one employee, (unlicensed personnel (ULP)-I). 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 November 5, 2024, at 8:06 a.m., the surveyor observed ULP-I while wearing gloves place a section of paper towel on R6's counter. ULP-I placed a blood glucose testing strip into a blood glucose meter. ULP-I used a lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood) on R6's pointer finger of R6's right hand. ULP-I used the paper towel to wipe away the first droplet of blood. ULP-I placed the	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF HERMANTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 4110 LAVAQUE ROAD HERMANTOWN, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 46 second droplet of blood onto the blood glucose testing strip to obtain a blood glucose reading of 85. The surveyor did not observe ULP-I clean R6's finger prior to lancet use. On November 5, 2024, at 8:09 a.m., ULP-I confirmed it was not her normal practice to clean an area prior to blood glucose testing. ULP-I stated she knew she was to clean the area prior to insulin administration. ULP-I's record included blood glucose monitoring training and supervision of glucose monitoring (competency) dated October 22, 2024. On November 5, 2024, at 9:34 a.m., clinical nurse supervisor (CNS)-C stated it was her expectation that a resident's finger should be cleaned before lancet use. Registered nurse (RN)-E stated he was not able to find a policy for blood glucose monitoring however he would print out the licensee's training procedure which included the cleaning of finger prior to blood glucose monitoring. The licensee's undated blood glucose monitoring education sheet noted: -cleanse the resident's fingertip with alcohol swab or have them wash hands (make sure hands are completely dry before testing). The licensee's Medication and Treatment Implementation policy reviewed August 1, 2021, noted the registered nurse (RN) would train staff and evaluate staff competency to carry out any delegated medication administration task or treatment that is new. The RN was responsible for assuring that the prescriptions and orders	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER THE PILLARS OF HERMANTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 4110 LAVAQUE ROAD HERMANTOWN, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 47 have been implemented appropriately through client monitoring, supervision of staff and review of client records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			

Type: Full
Date: 11/04/24
Time: 11:15:00
Report: 1006241164

Food and Beverage Establishment Inspection Report

Page 1

Location:

Pillars of Hermantown
4110 Lavaque Road
Hermantown, MN55811
St. Louis County, 69

Establishment Info:

ID #: N043849
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

MULTIPLE STAFF HAVE TAKEN A FOOD MANAGER'S COURSE, BUT DIDN'T SEND IN FOR THE STATE CERTIFICATE OR HAVE A CURRENT STATE CERTIFICATE. JONATHAN IS SIGNED UP TO TAKE A MANAGER'S COURSE AND EXAM-SEND IN THE STATE APPLICATION AFTER TAKING TO RECEIVE.

Comply By: 12/05/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

ONCE AT LEAST ONE STATE CERTIFIED FOOD MANAGERS CERTIFICATE IS RECEIVED POST IT SOMEWHERE IN THE FACILITY.

Comply By: 12/19/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HAND WASHING SINKS AT THE PUB HAND WASHING SINK AND IN BOTH THE MEN'S AND WOMEN'S RESTROOMS NEED HAND WASHING SIGNAGE. SIGNAGE EMAILED WITH REPORT.

Comply By: 11/11/24

Surface and Equipment Sanitizers

Type: Full
Date: 11/04/24
Time: 11:15:00
Report: 1006241164
Pillars of Hermantown

Food and Beverage Establishment Inspection Report

Page 2

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

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

Hot Water: = at 169F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 163 Degrees Fahrenheit - Location: BURGERS
Violation Issued: No

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: BURGERS
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 37 Degrees Fahrenheit - Location: DICED TOMATOES- TOP
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 37 Degrees Fahrenheit - Location: DICED CUCUMBERS- TOP
Violation Issued: No

Process/Item: Cooling
Temperature: 40 Degrees Fahrenheit - Location: SAUSAGES-~4 HRS
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: DICED HAM- BOTTOM
Violation Issued: No

Process/Item: Undercounter Freezer
Temperature: -2 Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 146 Degrees Fahrenheit - Location: MUSHROOMS AND ONIONS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: TURKEY BARLEY SOUP
Violation Issued: No

Process/Item: Undercounter Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Type: Full
Date: 11/04/24
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Pillars of Hermantown

Food and Beverage Establishment Inspection Report

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Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: RED PEPPER GRAVY
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: SALAD TOPPER
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: MASHED POTATOES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: AMBIENT AIR TEMP
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Beverage Dispenser
Temperature: 40 Degrees Fahrenheit - Location: ORANGE JUICE
Violation Issued: No

Process/Item: Beverage Dispenser
Temperature: 40 Degrees Fahrenheit - Location: APPLE JUICE
Violation Issued: No

Process/Item: Undercounter Cooler
Temperature: 38 Degrees Fahrenheit - Location: AMBIENT AIR TEMP- PUB COOLER
Violation Issued: No

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

COMMENTS:

INSPECTION ACCOMPANIED BY KITCHEN MANAGER, LOWELL FERMENICH.

KITCHEN IS CLEAN AND ORDERLY.

OBSERVED GOOD HAND WASHING AND GLOVE USE THROUGHOUT THE INSPECTION.
DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND EXCLUDING BARE HAND
CONTACT WITH ALL READY TO EAT FOODS.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH
SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR
AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE

Type: Full
Date: 11/04/24
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Report: 1006241164
Pillars of Hermantown

Food and Beverage Establishment Inspection Report

Page 4

DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY SUSPECTED FOODBORNE ILLNESS COMPLAINTS.

DISCUSSED THE FOOD RESTRICTIONS FOR A HIGHLY SUSCEPTIBLE POPULATION. FACT SHEET LEFT ON SITE AND EMAILED WITH REPORT.

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 1006241164 of 11/04/24.

Certified Food Protection Manager: None

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jonathan Benson

Signed: _____
Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006241164		Food Establishment Inspection Report									
 Minnesota Department of Health Food, Pools, & Lodging Services P.O. Box 64975 Saint Paul, MN 55164-0975		No. of RF/PHI Categories Out				2		Date		11/04/24	
		No. of Repeat RF/PHI Categories Out				0		Time In		11:15:00	
		Legal Authority MN Rules Chapter 4626						Time Out			
Pillars of Hermantown		Address 4110 Lavaque Road			City/State Hermantown, MN			Zip Code 55811		Telephone	
License/Permit # N043849		Permit Holder			Purpose of Inspection Full			Est Type		Risk Category	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS											
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item											
Mark "X" in appropriate box for COS and/or R											
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation											
Compliance Status						COS		R			
Supervision											
1		IN OUT		PIC knowledgeable; duties & oversight							
2		IN OUT N/A		Certified food protection manager, duties							
Employee Health											
3		IN OUT		Mgmt/Staff;knowledge,responsibilities&reporting							
4		IN OUT		Proper use of reporting, restriction & exclusion							
5		IN OUT		Procedures for responding to vomiting & diarrheal events							
Good Hygenic Practices											
6		IN OUT N/O		Proper eating, tasting, drinking, or tobacco use							
7		IN OUT N/O		No discharge from eyes, nose, & mouth							
Preventing Contamination by Hands											
8		IN OUT N/O		Hands clean & properly washed							
9		IN OUT N/A N/O		No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed							
10		IN OUT		Adequate handwashing sinks supplied/accessible							
Approved Source											
11		IN OUT		Food obtained from approved source							
12		IN OUT N/A N/O		Food received at proper temperature							
13		IN OUT		Food in good condition, safe, & unadulterated							
14		IN OUT N/A N/O		Required records available; shellstock tags, parasite destruction							
Protection from Contamination											
15		IN OUT N/A N/O		Food separated and protected							
16		IN OUT N/A		Food contact surfaces: cleaned & sanitized							
17		IN OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food							
GOOD RETAIL PRACTICES											
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.											
Mark "X" in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation											
						COS		R			
Safe Food and Water											
30		IN OUT N/A		Pasteurized eggs used where required							
31				Water & ice obtained from an approved source							
32		IN OUT N/A		Variance obtained for specialized processing methods							
Food Temperature Control											
33				Proper cooling methods used; adequate equipment for temperature control							
34		IN OUT N/A N/O		Plant food properly cooked for hot holding							
35		IN OUT N/A N/O		Approved thawing methods used							
36				Thermometers provided & accurate							
Food Identification											
37				Food properly labeled; original container							
Prevention of Food Contamination											
38				Insects, rodents, & animals not present							
39				Contamination prevented during food prep, storage & display							
40				Personal cleanliness							
41				Wiping cloths: properly used & stored							
42				Washing fruits & vegetables							
Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.											
Food Recalls:											
Person in Charge (Signature)						Date: 11/05/24					
Inspector (Signature)											